Semi-Annual Report to the

Joint Legislative Oversight Committee

on Mental Health, Developmental Disabilities and Substance Abuse Services

on

Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2007-08: Fall Report

Session Law 2006-142

House Bill 2077

Section 2.(a)(c)

October 1, 2007

North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Executive Summary

Legislation in 2006 requires the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to report to the Legislative Oversight Committee (LOC) every six months on progress made in seven statewide performance domains. This report is the third in a series of reports, with each report building upon previous reports. The following are highlights from each of the domains herein.

Highlights

Domain 1: Access to Services – The number of persons reported by local management entities (LMEs) as being served in communities across the state has been declining in recent years in every age-disability group except adults with mental health disorders and adults with developmental disabilities, whose numbers have increased. However, the LME data has been affected by changes in data reporting and sharing policies and the patterns are not confirmed by analysis of claims data. Almost all persons seeking emergent and urgent care are seen by a provider promptly after requesting services and approximately two-thirds of persons seeking routine (non-urgent) care are seen within seven days.

Domain 2: Individualized Planning and Supports – Almost three-fourths of families of consumers with developmental disabilities report choosing the provider agency that works with their family member, much higher than consumers in other states. Families in NC also report more involvement in the development of treatment plans than families in other states. The vast majority of consumers with mental health and substance abuse disorders report choosing their provider, services, and treatment goals. However, fewer adolescents report being involved in choosing their provider or services than other age groups.

Domain 3: Promotion of Best Practices – The number of persons receiving CAP-MR/DD waiver services has risen from approximately 6,400 in 2005 to over 9,000 in 2007. The number of persons receiving evidence-based services for mental health has remained fairly stable over the past fiscal year, while the number in evidence-based substance abuse services rose the first three quarters and fell in the fourth quarter. Admissions to state psychiatric hospitals have leveled off in the past three years, while readmissions within 30 days of discharge have remained low.

Domain 4: Consumer-Friendly Outcomes – Most North Carolina consumers with developmental disabilities report choosing where they live and work. Mental health and substance abuse consumers continue to show meaningful improvements in various aspects of their lives after three months of service.

Domain 5: Quality Management Systems – Monitoring of provider agencies has increased over the past two years from an average of 221 visits per month to 240 visits per month. Local quality improvement activities have focused on efforts to reduce consumer incidents and improve crisis services and continuity of care.

Domain 6: System Efficiency and Effectiveness – Local management entities' timely and accurate submission of information to the Division has improved somewhat in the last two quarters of SFY 2006-07, after falling during the previous four quarters. The LMEs used 85% of their state allocations for services over the fiscal year. Statewide, the percent of funds expended in SFY 2006-07 varied from a high of 92% for adult developmental disability services to a low of 38% for child substance abuse services.

Domain 7: Prevention and Early Intervention – In 2005, North Carolina received a Strategic Prevention Framework State Incentive Grant (SPF SIG) from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The SPF SIG is a five-year grant to promote data-driven planning to reduce the community-wide consequences of substance abuse in the state's most affected communities.

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Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2007-08: Fall Report

Legislative Background

Session Law 2006-142 Section 2.(a)(c) revised the NC General Statute (G.S.) 122C-102(a) to read:

> "The Department shall develop and implement a State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services. The purpose of the State Plan is to provide a strategic template regarding how State and local resources shall be organized and used to provide services. The State Plan shall be issued every three years beginning July 1, 2007. It shall identify specific goals to be achieved by the Department, area authorities, and area programs over a three-year period of time and benchmarks for determining whether progress is being made toward those goals. It shall also identify data that will be used to measure progress toward the specified goals…."

In addition, NC G.S. 122C-102(c) was revised to read:

> "The State Plan shall also include a mechanism for measuring the State's progress towards increased performance on the following matters: access to services, consumer friendly outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, and prevention and early intervention. Beginning October 1, 2006, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, on the State's progress in these performance areas."

Quality Management Activities Since the Spring 2007 Report

The following is the third in the series of reports required by the legislation cited above. Since the April 2007 report, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the Division) has worked with its stakeholders and consultants funded by the General Assembly through Session Law 2006-66 (Senate Bill 1741) to develop and publish *Transformation of North Carolina's System of Services for Mental Health, Developmental Disabilities, and Substance Abuse: State Strategic Plan 2007-2010* (available on the Division's website at http://www.ncdhhs.gov/mhddsas/index.htm). The same consultants are currently assisting the Division to develop indicators of progress on the Strategic Plan objectives, which include:

- Developing a stable and high quality provider system
- Developing comprehensive crisis services
- Integrating and standardizing processes and procedures
- Improving consumer outcomes related to housing
- Improving consumer outcomes related to education and employment

In addition to completing this major planning process and beginning its implementation, the Division has accomplished a number of other important activities that relate to the *State Strategic Plan 2007-2010* objectives and to continued refinement of a data-driven, improvement-focused quality management system. Major activities include:

- **Developing an annual Performance Contract between the Department of Health and Human Services and each local management entity (LME)**. This new contract, which will replace the existing three-year contracts, includes a standardized scope of work detailing the components of each function that the LMEs are expected to perform and critical performance indicators for each function, as required by S.L. 2006-142, Section 4.(m).

- **Providing direction and technical assistance to LMEs in developing Local Business Plans.** The Division has directed LMEs in how to use the *State Strategic Plan 2007-2010* objectives and data from the *Community Systems Progress Indicators Reports*, published on the Division website at http://www.ncdhhs.gov/mhddsas/index.htm each quarter since the beginning of SFY 2006-2007, to identify areas of local strength and weakness to guide the choice of strategic objectives.

- **Completing a review of the LMEs' screening, triage, and referral function.** The Division conducted a review of the LMEs' capacity to support consumers' access to the service system in a user-friendly and timely manner. The Division is currently working to ensure improvements in LMEs that were found deficient in this function.

- **Conducting standardized post-payment reviews of community support services.** The Division, the LMEs, and the Division of Medical Assistance (DMA) have collaboratively developed and implemented a process for comprehensive oversight of the provision of services, beginning with community support services. Review of other services will be added during SFY 2007-2008.

- **Completing a comprehensive assessment of the community-level consequences of substance abuse**. This project was conducted with Strategic Prevention Framework State Incentive Grant (SPF SIG) funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) in collaboration with other state agencies, universities, and local researchers. It has resulted in prioritization of statewide issues related to substance abuse and identification of eighteen counties with the highest rates of the top priority problem – alcohol-related vehicle crashes. These counties will be targeted for funding and assistance to address this problem over the next three years, using locally-relevant strategies.

- **Hosting the first statewide Quality Management Conference.** This conference, using grant funds from the Center for Medicare and Medicaid Services (CMS), brought together collaborative teams of LME and provider staff and consumer and family members from each local area to focus on using data to drive quality assurance, quality improvement, and planning efforts.

Measuring Statewide System Performance

The domains of performance written into legislation reflect the goals of the President's New Freedom Initiative and national consensus on goals that all states should be working toward, specifically to provide support for individuals with disabilities to be able to live productive and personally fulfilling lives in communities of their choice. The Division has chosen measures that can be used to evaluate the implementation of system reform efforts and the impact on system performance and consumers' lives. The measures relate to:

- The strategic objectives of the *State Strategic Plan 2007-2010*.
- SAMHSA National Outcome Measures (NOMS) (See Appendix A for details).
- Areas of quality recommended in the CMS Quality Framework (See Appendix B for details).

Where applicable, the Division is also aligning measures of statewide performance with local performance indicators published in the *Community Systems Progress Indicators Reports* each quarter, so that each LME can evaluate its own progress in relation to the state as a whole.

The performance measures chosen for this third report to the Joint Legislative Oversight Committee are a result of continuing work in this effort. This report provides an update and/or refinement of the items in the Fall 2006 Report that are appropriate for annual measurement and an update on items in the Spring 2007 Report that are appropriate for semi-annual measurement.

For each performance area, the following sections include:

- A description of the domain.
- A statement of its relevance to system reform efforts and importance in a high-quality system.
- One or more measures of performance for that domain, each of which includes:
    - A description of the indicator(s) used for the measure.
    - The most current data available for the measure.
    - Division expectations about future trends and plans for addressing problem areas.

Appendices at the end of this report provide information on the data sources for the information included in each domain.

Domain 1: Access to Services

Access to Services refers to the process of entering the service system. This domain measures the system's effectiveness in providing easy and quick access to services for individuals with mental health, developmental disabilities and substance abuse disabilities who require help. Timely access is essential for helping people get care during times of their greatest vulnerability and/or openness to assistance. It is the first step in engaging people in care long enough to improve or restore personal control over their lives, to prevent future crises and to minimize the impact of disabilities on their lives. Both the SAMHSA National Outcome Measures and CMS Quality Framework, as well as the Division's *Community System Progress Indicators Reports*, include measures of consumers' access to services.

Measure 1.1: Persons Receiving Community Services

The Division is committed to serving individuals with mental health, developmental disabilities, and substance abuse needs in their communities rather than in institutional settings whenever possible. Tracking the number of persons that the LMEs serve in communities provides a barometer of progress on that goal.

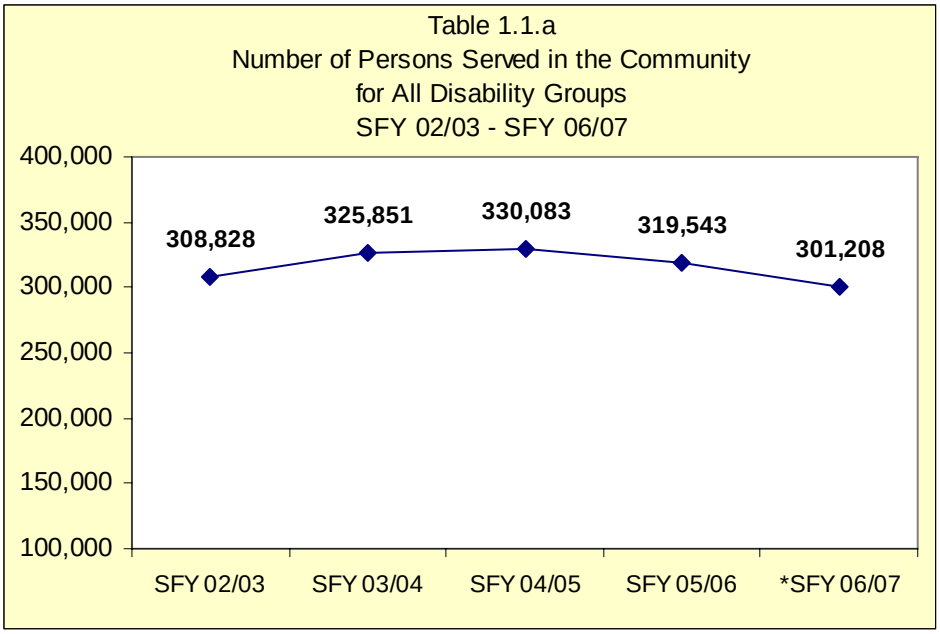
Measure 1.1 contains information on the number of persons that the state's mental health, developmental disabilities and substance abuse system has served over the past five state fiscal years. In the following

three tables, the number of persons served is determined from data submitted to the Division's Client Data Warehouse (CDW) by the LMEs.[1]

Based on data the LMEs submit, Table 1.1.a. shows that the number of persons who have been served in the community over the past five state fiscal years experienced a considerable increase in the first three fiscal years, but has been on the decline since SFY 2004-05. This decrease is, at least in part, due to changes in data submission and data sharing policies.

As stated in the Fall 2006 Report, the Division began a requirement in SFY 2005-06 for LMEs to complete a discharge record on consumers who had not received any service for sixty days (or 365 days for adult mental health consumers in recovery) in order to improve the accuracy of data on persons being *actively* served. As expected, this has resulted in the closing of *inactive* records, which is reflected in the decrease since the implementation of this requirement.

The decrease shown in Table 1.1.a also reflects the LMEs' lack of access to complete information on individuals admitted for Medicaid-funded services between April 2006 and April 2007. Since providers started billing Medicaid directly in April 2006, they have been required to register new consumers with the LMEs. However, the LMEs did not have Medicaid service claims data to verify the number of expected registrations until confidentiality issues were resolved in April 2007. This gap in information hampered LME efforts to enforce the registration requirement. The claims data now being provided to them will support their monitoring of providers' submission of data on new Medicaid-funded consumers.



As a result of these policy changes, the Division expects to report greater accuracy and improvements in the number of persons served through LMEs in the future. This expectation is supported by analysis of service claims data, as reported in the quarterly *Community Systems Progress Indicator Reports*. These reports indicate a gradual increase in the percent of persons in need who

[1] SFY 2006-07 numbers are based on preliminary data. Official numbers for total persons served in SFY 2006-2007 will be available in November 2007 and will be updated in future reports. The numbers for SFY 2005-2006 have been updated since the Fall 2006 Report.

received mental health and developmental disabilities services over the course of SFY 2006-07. However, the percent of those receiving needed substance abuse services decreased somewhat over the same period.

Table 1.1.b. shows differing patterns by disability for the number of adults who have been served in the community over the past five state fiscal years. These patterns mirror those found in analysis of service claims data.

- **Adults with a primary mental health diagnosis:** The number of adults served in the community over the past five years has increased by 11%.
- **Adults with a primary developmental disability diagnosis:** The number of adults served in the community over the past five years has increased by 19%.
- **Adults with a primary substance abuse diagnosis:** The number of adults served in the community over the past five years has decreased by 24%.

It is encouraging to see services to adults with mental health problems and developmental disabilities increasing over the past five years. However, it is troubling to see a significant continued downward trend since SFY 2003-04 in services to adults with substance abuse problems.

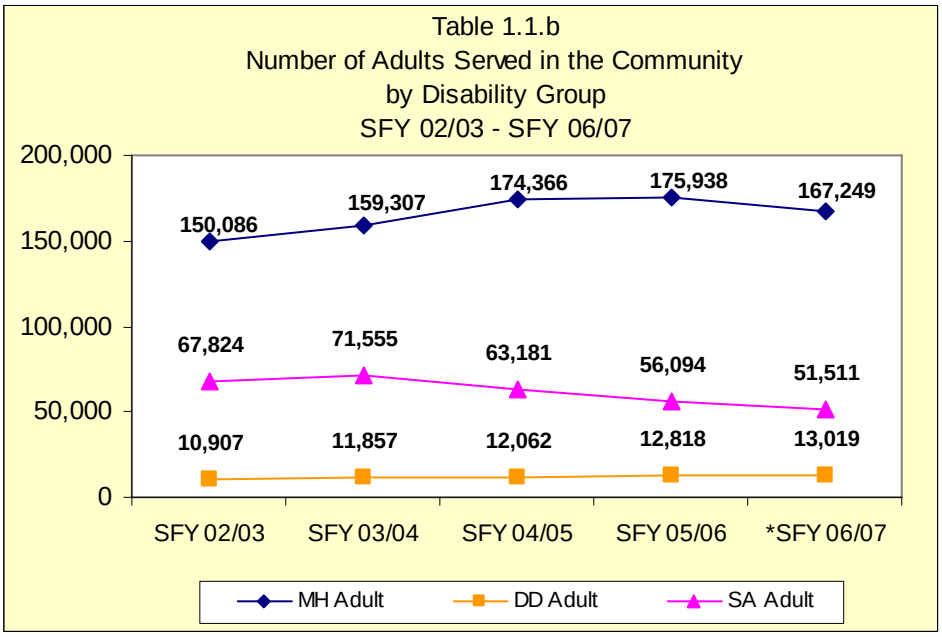
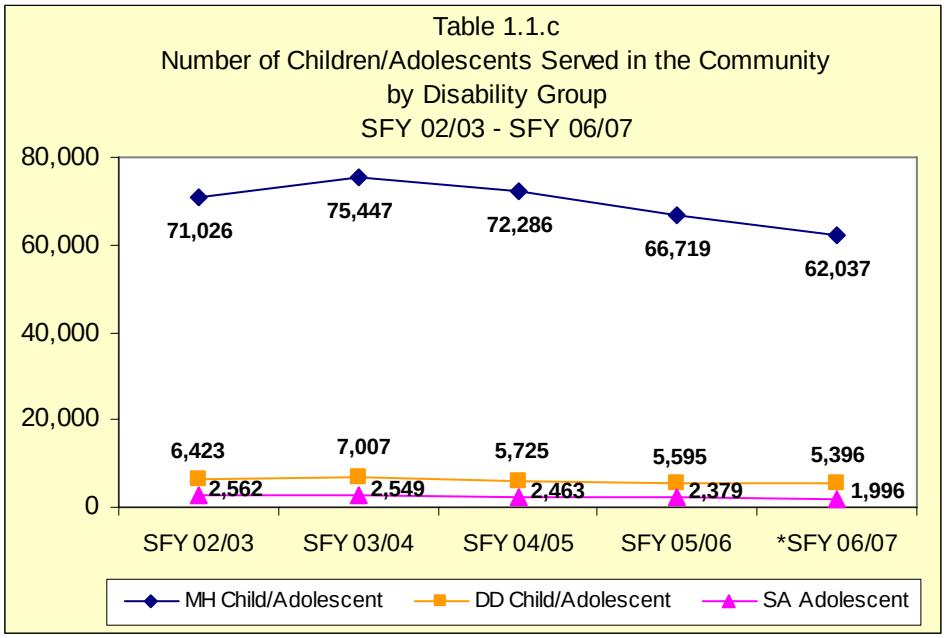


Table 1.1.c shows the number of children and/or adolescents who received state-funded services in the community over the past five state fiscal years as reported by LMEs. All of the disability groups saw a decrease in the number of children and/or adolescents served in the community over the past five years.

- **Children/Adolescents with a primary mental health diagnosis:** The number of children and adolescents served in the community over the past five years has decreased by 13%.
- **Children/Adolescents with a primary developmental disability diagnosis:** The number of children and adolescents served in the community over the past five years has decreased by 16%.
- **Children/Adolescents with a primary substance abuse diagnosis:** The number of adolescents served in the community over the past five years has decreased by 22%.

The pattern for children and adolescents receiving mental health and developmental disability services is at least in part a reflection of efforts to improve data accuracy, as cited above. This assertion is supported by analysis of the service claims data that shows an increase in these services to children and adolescents during SFY 2006-07. However, similar to the pattern for adults, service claims data show a decline in substance abuse services to adolescents similar to that reported in Table 1.1.c.



The Division is working closely with LMEs and providers to identify and implement strategies to better engage children and adolescents with substance abuse problems.

Measure 1.2: Timeliness of Initial Service

Timeliness of Initial Service is a nationally accepted measure[2] that refers to the time between an individual's call to an LME or provider to request service and their first face-to-face service. A system that responds quickly to a request for help can prevent a crisis that might otherwise result in greater trauma to the individual and more costly care for the system. Responding when an individual is ready to seek help also supports his or her efforts to enter and remain in services long enough to have a positive outcome.

Individuals who request care during crisis situations are usually seen very quickly. In the last quarter of SFY 2006-07:

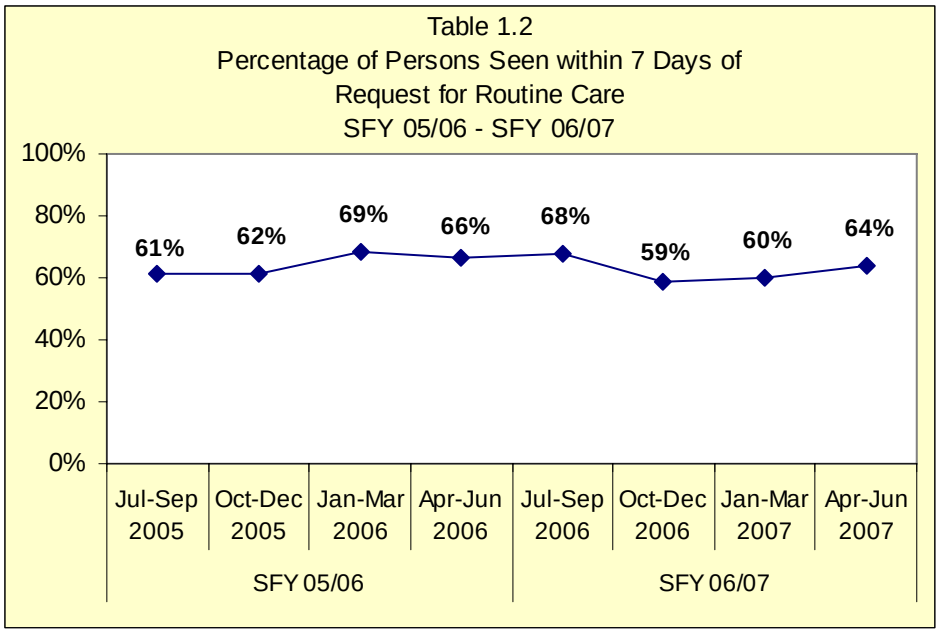
- 98% of those requesting care in emergency situations were seen within two hours.
- 82% of those requesting care in urgent situations were seen within 48 hours.

The percent of persons requesting routine (non-urgent) services who were *offered an appointment* within seven days was 83% as reflected in the fourth quarter of SFY 2006-07. However, not all individuals keep

[2] Health Plan Employer Data and Information Set (HEDIS©) measures.

those appointments. Follow-up by the LME or provider is often necessary to ensure that individuals keep or reschedule appointments.

Table 1.2 below shows the percentage of all consumers seeking routine care over the past two state fiscal years who were *actually seen* by a provider within seven days of requesting services. During this time, there has been a slight increase (3%) in the percent of persons seen quickly, as predicted in the Spring 2007 Report.



Further improvements on this measure of access will require more stability within the community-based provider system and better coordination between the LMEs and their providers. The Division expects LMEs to have systems in place to schedule an appointment with an appropriate provider while the individual requesting care is still on the telephone and to follow up with individuals who miss appointments. The Division will be monitoring the LMEs' progress in this matter as part of the new *DHHS-LME Performance Contract*. **As a result of this monitoring and efforts to stabilize the provider system, the Division expects performance on this measure to continue to improve.**

Domain 2: Individualized Planning and Supports

Individualized Planning and Supports refers to the practice of tailoring services to fit the needs of the individual rather than simply providing a standard service package. It addresses an individual's and/or family's involvement in planning for the delivery of appropriate services. Services that focus on what is important to individuals (and to their families when appropriate) are more likely to engage them in service and encourage them to take charge of their lives. In addition, services that address what is important for them produce good life outcomes more efficiently and effectively.

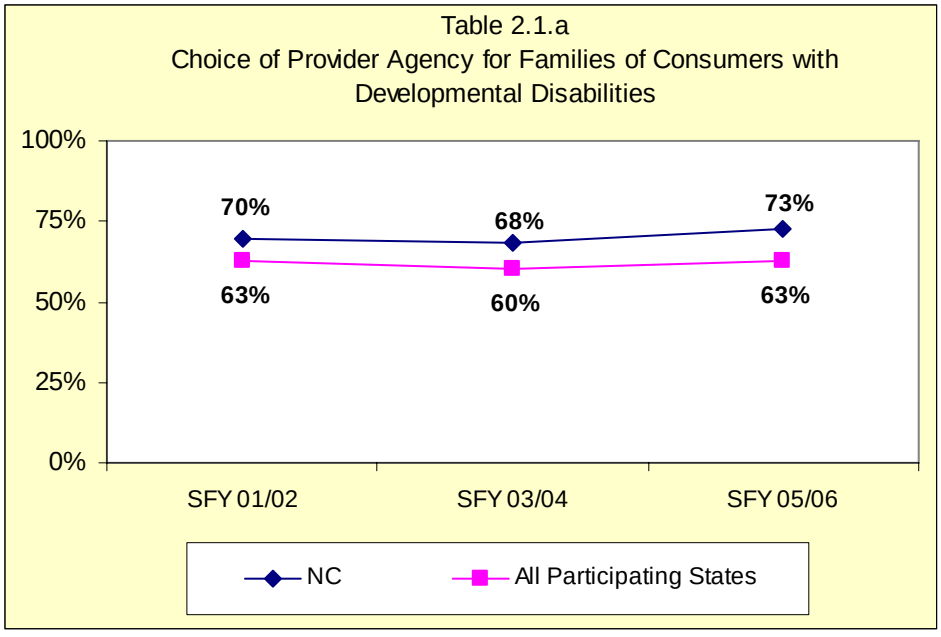
The CMS Quality Framework encourages measuring the extent to which consumers are involved in developing their service plans, have a choice among providers, and receive assistance in obtaining and moving between services when necessary.

Measure 2.1: Consumer Choice of Providers

Offering choices is the initial step in honoring the individualized needs of persons with disabilities. The ability of a consumer to exercise a meaningful choice of providers depends first and foremost on having a sufficient number of qualified providers to serve those requesting help. As of June 30, 2007, the LMEs had over 2,700 active agencies providing community-based services across the state.[3]

Finding the right provider and situation can mean the difference between willing engagement in services or discontinuation of services before recovery or stability can be achieved. With sufficient provider capacity, consumers have an opportunity to select services from agencies that can meet their individual scheduling and transportation requirements, address their individual needs effectively and encourage them in a way that feels personally comfortable and supportive. The tables on the following pages address the extent to which individuals report having a choice in who serves them and/or the services they receive.

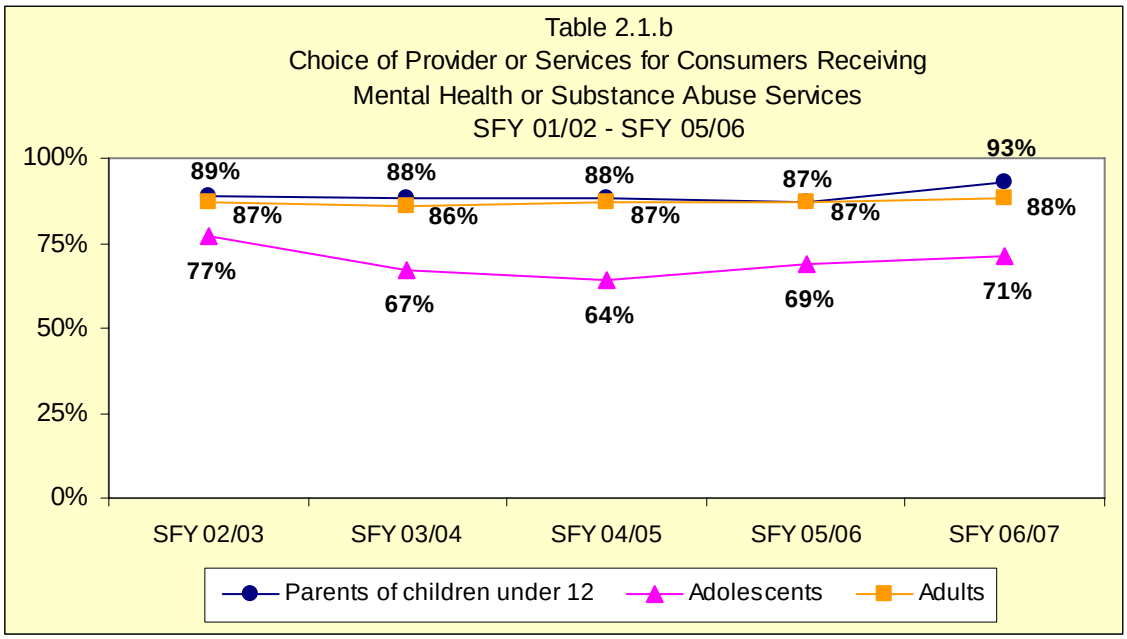
Consumers with Developmental Disabilities (Table 2.1.a): In annual surveys of families of persons with developmental disabilities who live at home, respondents in North Carolina have consistently reported more choice in providers to work with their families compared to the average among all states participating in the survey, as shown in Table 2.1.a. (See Appendix C for more information on the National Core Indicators surveys.) Data from the most recent fiscal year shows a slight increase over previous years, with almost three-fourths of survey respondents in North Carolina reporting that they choose the provider agency who works with their family member.



Consumers with Mental Health and Substance Abuse Disabilities (Table 2.1.b): In the annual Division survey of persons with mental health or substance abuse disabilities, a large majority reported positive feedback regarding their providers and the services they received. This positive trend has increased slightly over the past five years of the consumer survey among adults and parents of children under the age of twelve. Adolescents were less likely than these two groups to report helping to choose

[3] See Appendix C for details.

their services, but have shown an upward trend in the last two years. (See Appendix C for more information on the Mental Health Statistical Improvement Project Consumer Survey.)



These results provide encouragement that system reform is offering opportunities for consumers to have input into their services. **The Division expects the current positive trends to continue on this measure.**

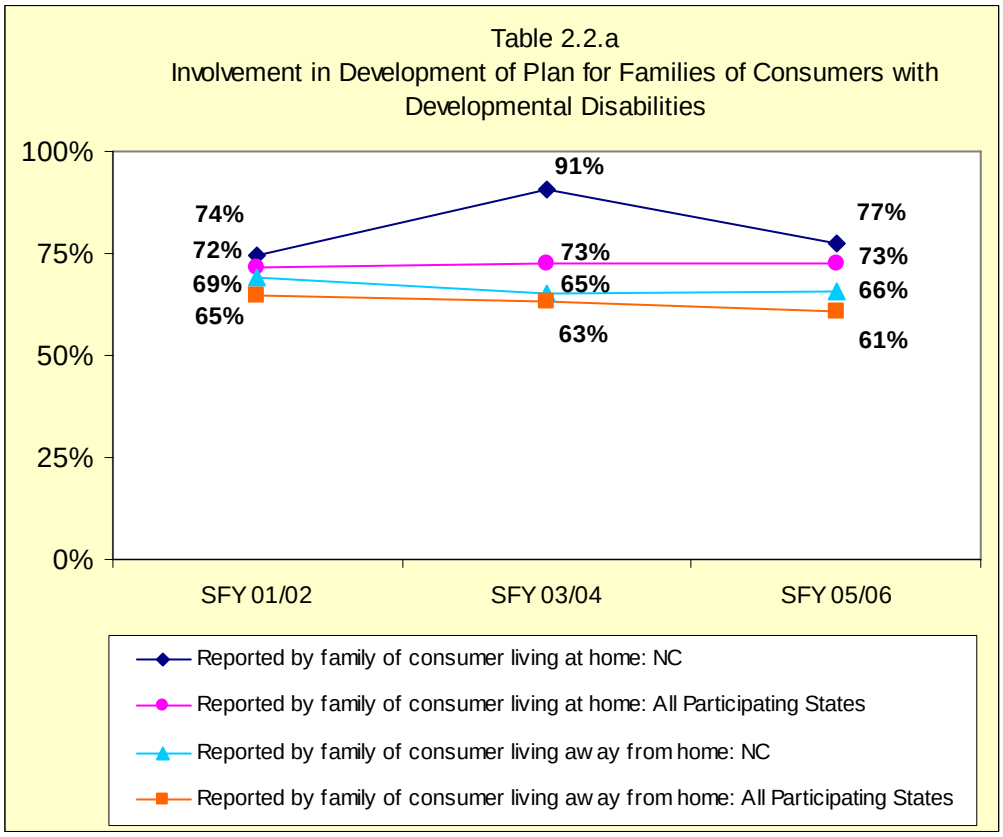
Measure 2.2: Person-Centered Planning

A Person-Centered Plan (PCP) is the basis for individualized planning and service provision. It allows consumers and family members to guide decisions on what services are appropriate to meet their needs and goals and tracks progress toward those goals. The Division requires a PCP for most persons who receive enhanced benefit services,[4] and has implemented a standardized format and training to ensure statewide adoption of this practice. The Division is currently working with a consultant to refine mechanisms to measure the implementation and quality of this important foundation of a consumer-centered system.

As the following tables show, a large majority of consumers are involved in the service planning and delivery process.

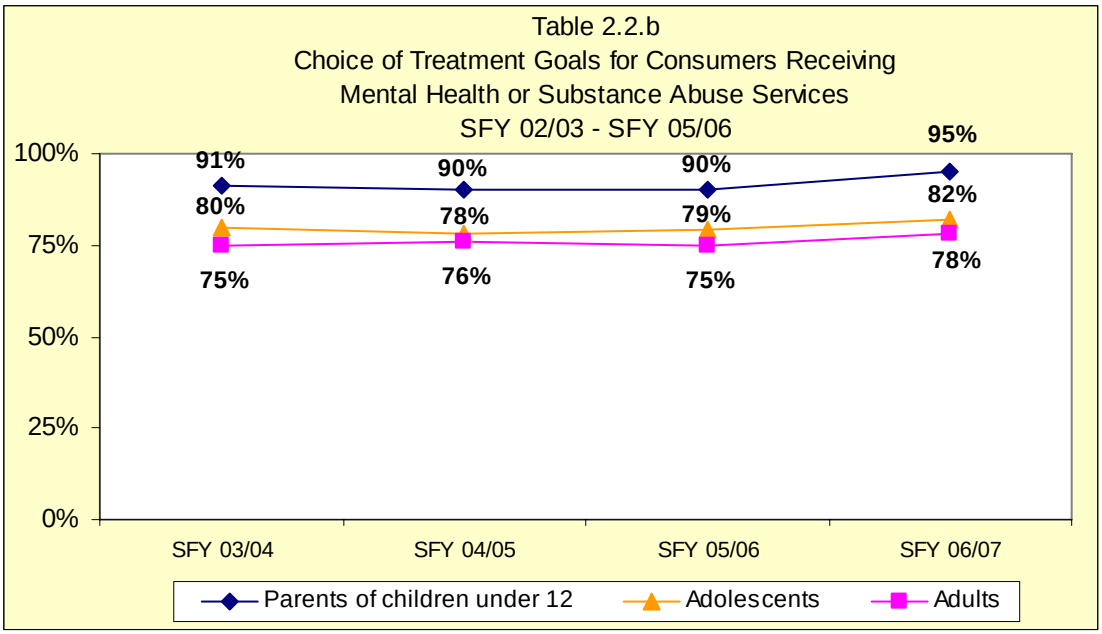
Consumers with Developmental Disabilities (Table 2.2.a): As shown in Table 2.2.a on the next page, families of consumers with developmental disabilities report more involvement in the development of treatment plans for their family members compared to the average for all states participating in the annual survey. (See Appendix C for more information on this survey.) This table also shows that families of consumers living at home report considerably more involvement in the development of treatment plans than those where the consumer lives away from the home.

[4] "The enhanced benefit service definition package is for persons with complicated service needs." *State MH/DD/SAS Plan 2005*, p. 58.



<u>Consumers with Mental Health and Substance Abuse Disabilities (Table 2.2.b)</u>: For the last four fiscal years, the Division has asked mental health and substance abuse consumers about their having a choice of treatment goals. As Table 2.2.b shows on page 14, the vast majority of mental health and substance abuse consumers in the annual survey have consistently reported choosing or helping to choose their treatment goals across all groups reporting: parents of children under the age of 12, adolescents, and adults. Adults reported having less input into their treatment goals compared to parents of children under the age of 12 and adolescents, but like the other two age groups, have shown some improvement in the past year.

The state has made immense efforts to institute a system of care that strongly encourages consumer and family participation in service planning and delivery. The Division, LMEs and providers must continue to incorporate person-centered thinking into all aspects of the service system. This is a major shift in philosophy that will require time, diligence and collaboration to achieve fully. The new *<u>DHHS-LME Performance Contract SFY 2007-2008</u>* requires each LME to review consumers' PCPs to ensure the appropriateness of services and progress toward recovery and community stability. **As a result of these LME activities and continued learning among all parties in the service system, the Division expects to see this positive trend continue to improve in coming years.**



Domain 3: Promotion of Best Practices

This domain refers to adopting and supporting those models of service that give individuals the best chance to live full lives in their chosen communities. It includes support of community-based programs and practice models that scientific research has shown to result in improved functioning of persons with disabilities, as well as promising practices that are recognized nationally. SAMHSA requires states to report on the availability of evidence-based practices as part of the National Outcome Measures.

Supporting best practices requires adopting policies that encourage the use of natural supports, community resources and community-based service systems; funding the development of evidence-based practices; offering incentives to providers who adopt those practices and providing oversight and technical assistance to ensure the quality of those services.

The North Carolina Practice Improvement Collaborative (NC PIC) provides guidance to the Division in determining the evidence-based practices that will be provided through our public system. With representatives of all three disabilities, the NC PIC meets quarterly to review and discuss practices that have been submitted for evaluation, examine issues that affect the readiness of the practice for adoption in our state, and to prioritize recommendations for the Division Director.

The Division is currently working with DMA and LMEs to monitor and improve the implementation of the new service definitions adopted in March 2006 that reimburse providers for using best practice models of care. The Division also continues to provide grant funds for four LMEs (Durham, CenterPoint, Wake and Catawba) to develop the infrastructure within each LME that will promote and sustain the local use of best practices, as described in the Spring 2007 Report. As pilot programs, these LMEs are identifying the activities other LMEs will need to undertake to build a highly effective service system across the state.

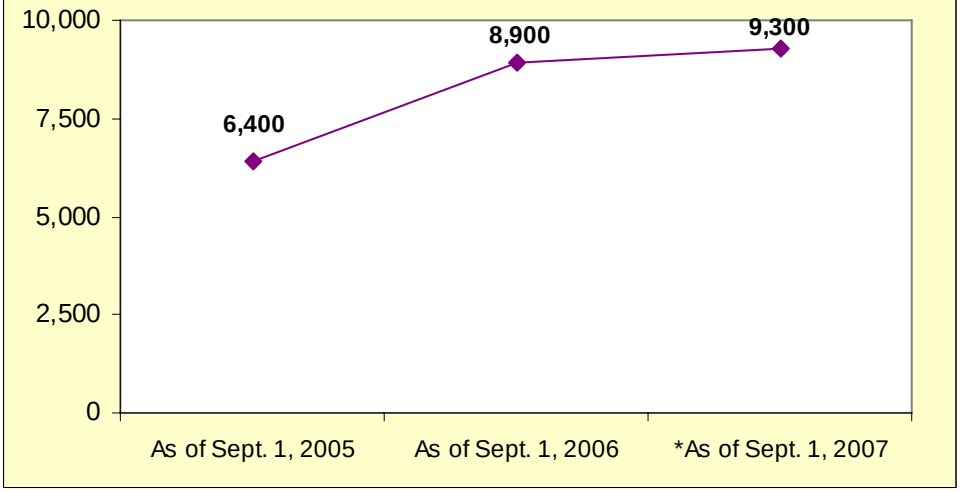
Measure 3.1: Persons Receiving Evidence-Based Practices

For consumers with developmental disabilities, the state currently has about 600 providers to deliver services and supports for up to 10,000 individuals through the Community Alternatives Program for

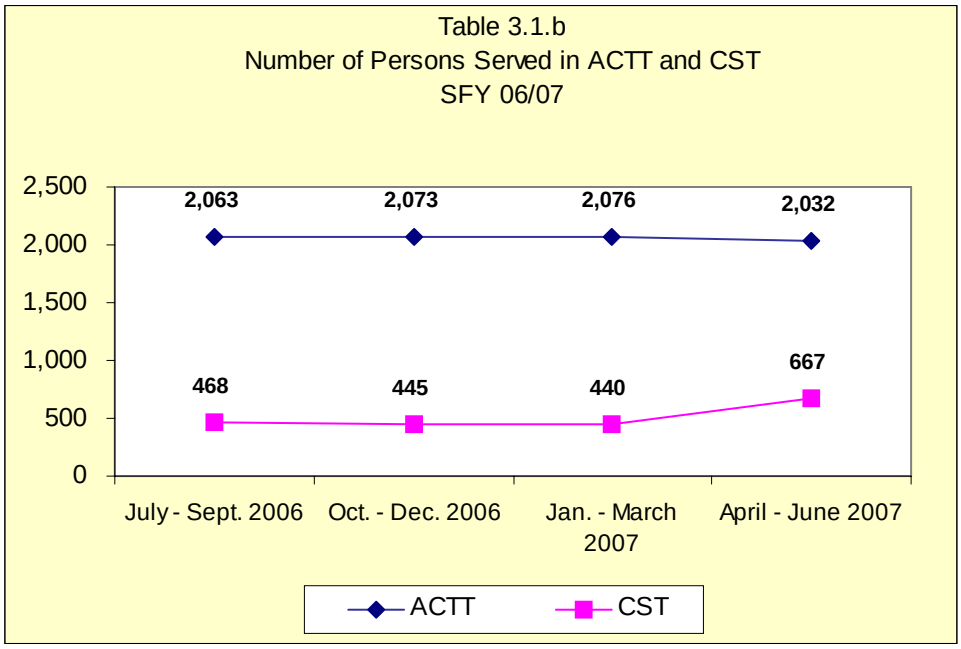
Mental Retardation and Developmental Disabilities (CAP-MR/DD), a Home and Community Based Waiver granted by CMS. Home and Community Based Services waiver programs permit a state to furnish an array of home and community based services that promote community living for eligible individuals, thereby avoiding institutionalization. Waiver services are designed to be flexible enough to fit an individual's changing needs, and as such, represent a best-practice approach to supporting individuals with developmental disabilities.

At implementation of the CAP-MR/DD waiver in September 2005 approximately 6,400 consumers were being served through the CAP-MR/DD waiver. At the beginning of the second year of the waiver (September 2006), approximately 8,900 consumers received services through the waiver. It is anticipated that at the beginning of the third waiver year approximately 9,300 consumers will receive waiver services at an average cost per person of $43,000 per year (see Table 3.1.a below). **The Division expects to allocate additional waiver slots this fall.**

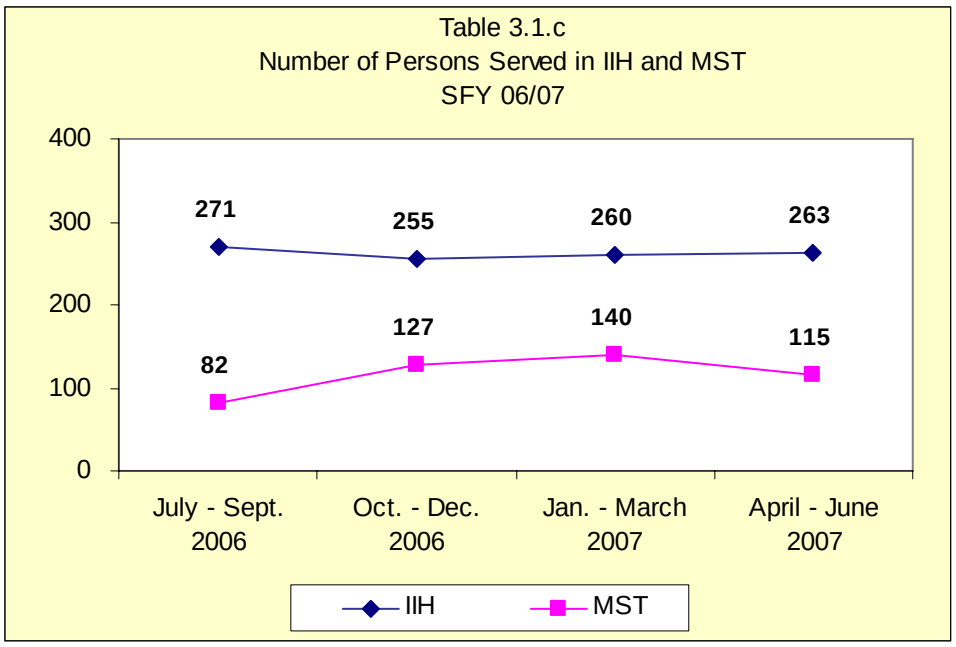
Table 3.1.a
Number of Persons Receiving CAP-MR/DD Waiver Services
Waiver Years 1 - 3



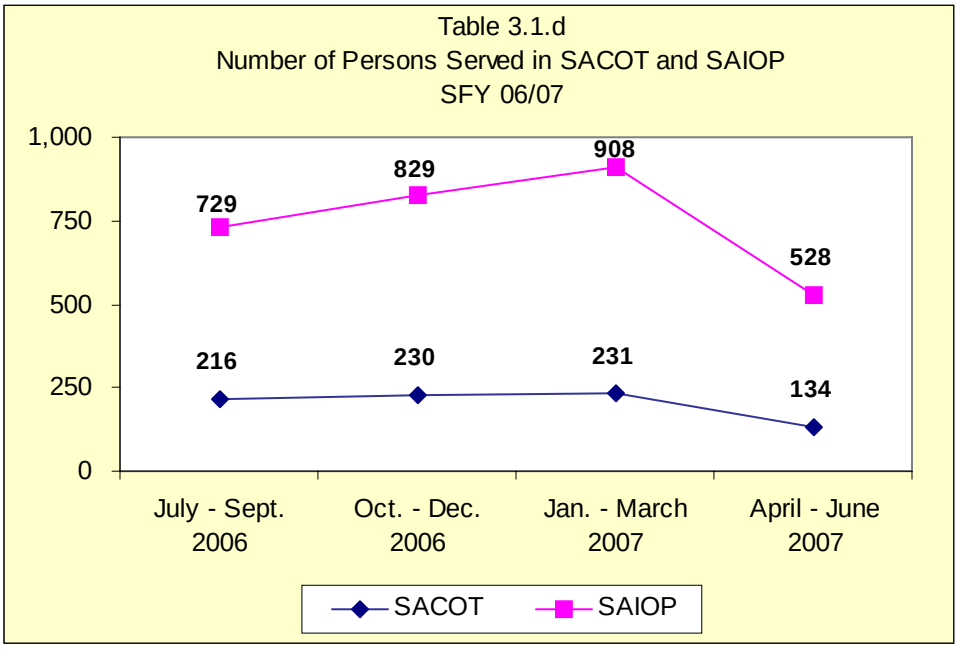
Adults with severe and persistent mental illnesses often need more than outpatient therapy or medications to maintain stable lives in their communities. Community support teams (CST) and assertive community treatment teams (ACTT) are designed to provide intensive, wrap-around services to prevent frequent hospitalizations for these individuals and help them successfully live in their communities. As shown in Table 3.1.b, on page 16, the number of persons served in ACTT has remained fairly stable over the past five years, while the number of persons served in CST has increased 42% during the past year. **The Division expects to see continued improvements in the availability of CST.**



Best practice services that support community living for children and adolescents with severe emotional disturbances and/or substance abuse problems require involvement of the whole family. Two of these best practices – intensive in-home (IIH) and multi-systemic therapy (MST) – help reduce the number of children who require residential and inpatient care. Table 3.1.c shows that the number of persons served in IIH has remained fairly stable during the past fiscal year. However, the number of persons served in MST has jumped 40% since the first quarter of SFY 2006-07. The increase in MST reflects the expansion of statewide provider agencies and their coordination with LMEs. The Division is currently working to educate providers on the appropriate use of community support services as a way to identify children and adolescents who would be better served through IIH services. **As a result of these efforts, the Division expects to see the number of children receiving IIH to also grow in the future.**



Recovery for individuals with substance abuse disorders requires service to begin immediately when an individual seeks care and to continue with sufficient intensity and duration to achieve and maintain abstinence. The substance abuse intensive outpatient program (SAIOP) and comprehensive outpatient treatment (SACOT) models support those intensive services using best practices, such as motivational interviewing techniques. However, both SAIOP and SACOT have seen a decrease in the number of persons served during the last state fiscal year, as seen in Table 3.1.d below. After rising 25% during the first three quarters of the year, the number of persons served in SAIOP dropped dramatically (58%) in the fourth quarter. The number of persons receiving SACOT also dropped 58% during the fourth quarter after a slight gradual climb earlier in the year. The reasons for this pattern are not clear. Possible explanations could include slow billings or payments for service claims, a possible loss of provider capacity, seasonal variations in help-seeking behaviors among persons with substance abuse issues, or other issues. **The Division is greatly concerned about the drop and will be conducting further data analysis to investigate the causes and appropriate responses.**



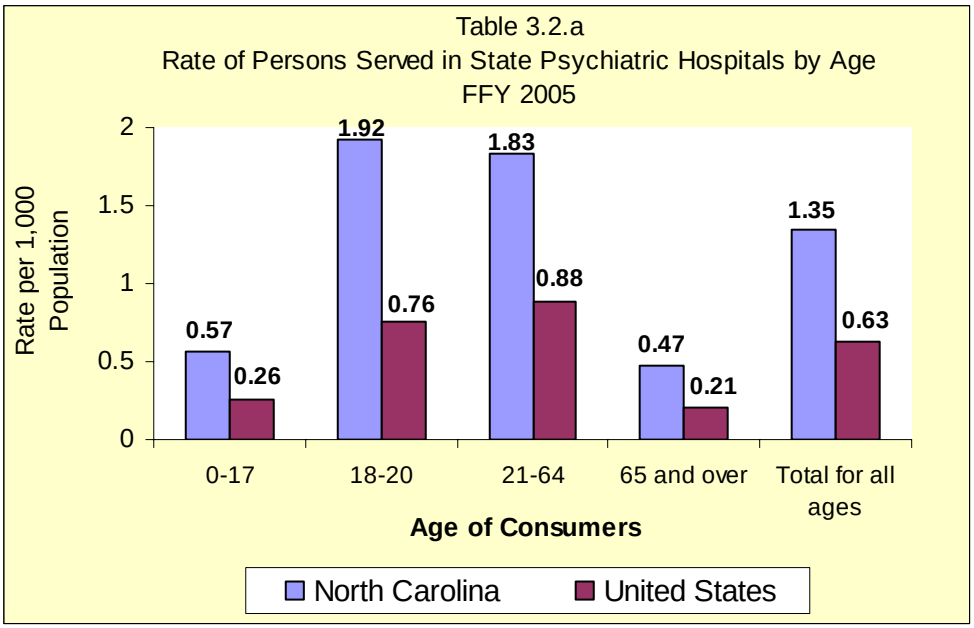
Measure 3.2: Use of State Operated Services

A service system in which individuals receive the services and supports they need in their home communities allows them to stay connected to their loved ones. This is a particularly critical component of recovery or self-determination in times of crisis. Service systems that concentrate on preventing crises and providing community-based crisis response services can help individuals maintain support from their family and friends, while reducing the use of state-operated psychiatric hospitals in times of acute crisis.

As stated in the Fall 2006 Report, North Carolina has historically used its state psychiatric hospitals to provide more short-term care (30 days or less) than other states. In most other states, acute care is provided in private hospitals, reserving the use of state psychiatric hospitals for consumers needing long-term care. North Carolina, however, has historically served more people overall in its state psychiatric hospitals than other states and with shorter average lengths of stay.

According to Table 3.2.a, on the next page, North Carolina continues to provide treatment for persons in its state psychiatric hospitals at more than twice the national rate across all ages, according to the most recent report (federal fiscal year (FFY) 2005) from the Center for Mental Health Services (CMHS). A

fundamental goal of the state's system reform efforts has been to reduce the short-term use of state psychiatric hospitals. **The Division expects to see this measure positively impacted in coming years by the ongoing implementation of crisis plans by all LMEs.**



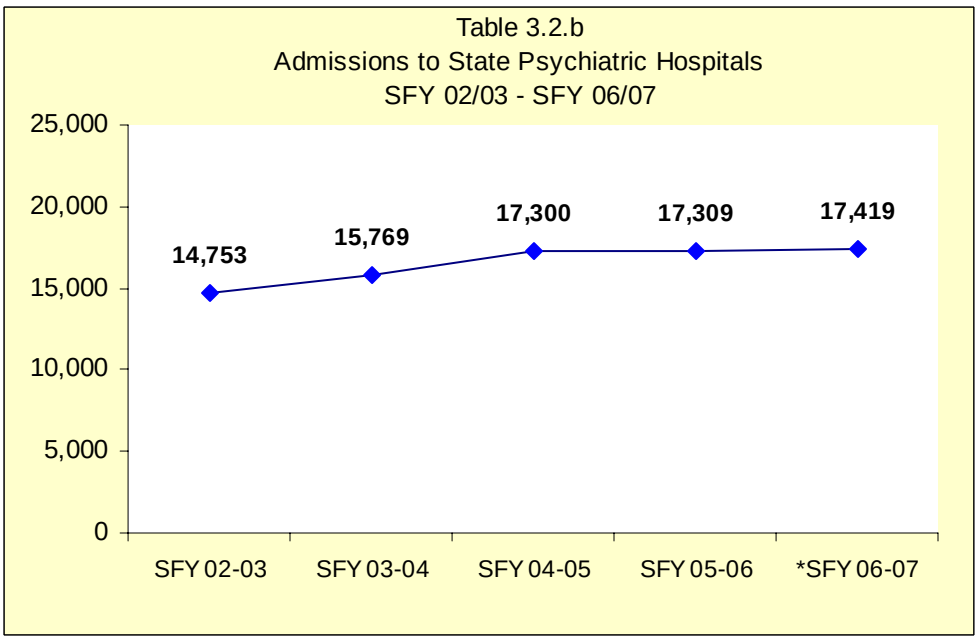
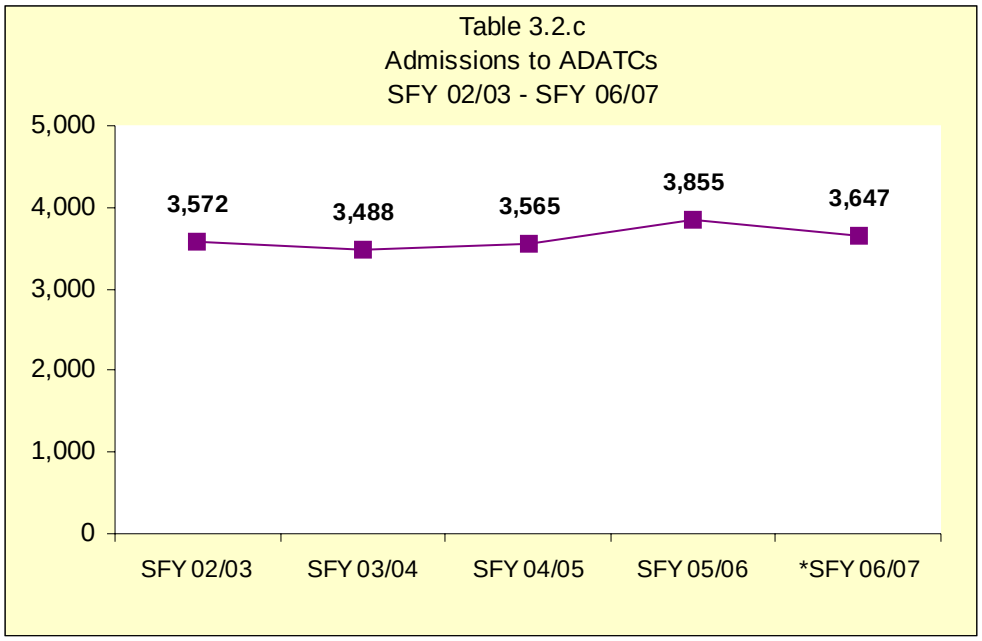


Table 3.2.b shows that the number of admissions to the state psychiatric hospitals over the past five years has begun to stabilize.[5] The greatest increase occurred between SFY 2002-2003 and SFY 2004-2005, when admissions rose by 17%. The number of admissions has grown by less than 1% over the two years since then. **The Division expects continued efforts by the Division, LMEs, and providers to improve**

[5] The numbers for SFY 2006-07 are preliminary. They will be final in November 2007 and updated in future reports.

local crisis systems to continue stabilizing and to begin reducing the number of admissions in the future.

In contrast to efforts to *reduce* the use of state psychiatric hospitals for short-term care, the Division continues working to *increase* the use of state alcohol and drug treatment centers (ADATCs) for acute care. ADATCs are critical resources to serve individuals who are exhibiting primary substance abuse problems that are beyond the treatment capacity of local community services, but for whom psychiatric hospitalization is not appropriate. As shown in Table 3.2.c below, total admissions to all ADATCs has increased slightly from 3,572 in SFY 2002-03 to 3,647 in SFY 2006-07 (a 2% increase).[6] **The Division expects that the opening of new acute units in the near future will result in a greater use of ADATCs for detoxification and short-term care and a decrease in inappropriate admissions of primary substance abuse consumers to psychiatric hospitals.**

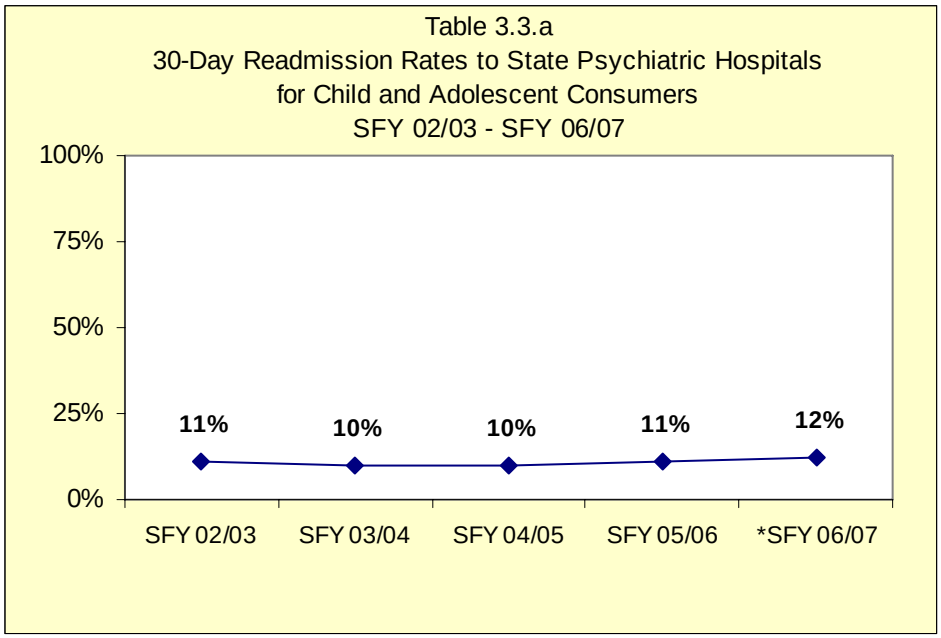


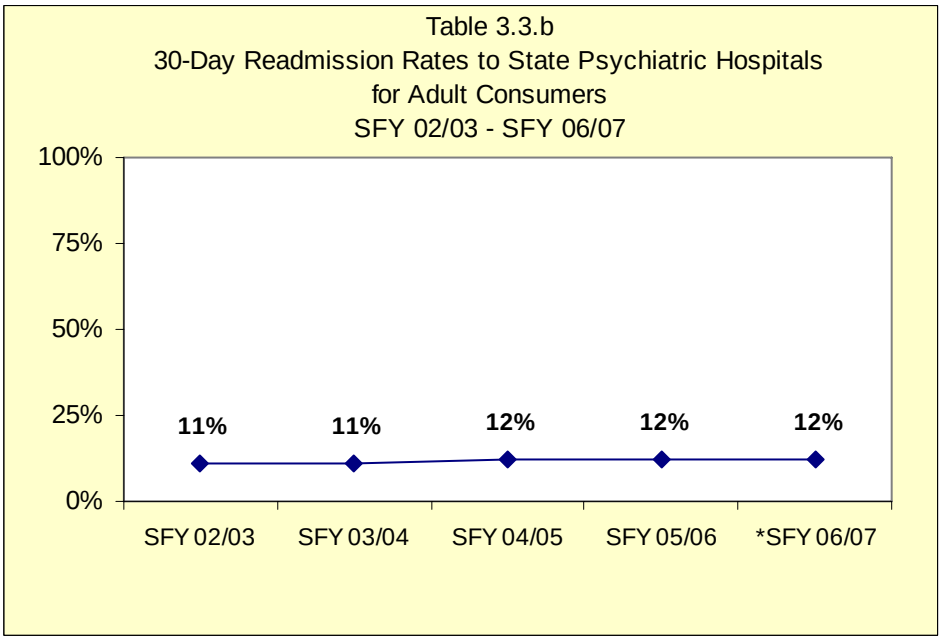
Measure 3.3: State Psychiatric Hospital Recidivism

An effective service system provides enough support to help prevent consumer crises and minimize their impact through appropriate planning and treatment. Recurring hospitalization for persons who are likely to experience frequent crises is a signal that additional supports are needed. Tracking hospital readmissions within 30 days of discharge is a critical measure of consumer care (adopted by SAMHSA's Center for Mental Health Services) that provides the Division with information on where more comprehensive services might be needed.

Tables 3.3.a and 3.3.b show there has been very little change over the past five years in the percent of child and adult consumers requiring readmission to state hospitals within 30 days of discharge.[6] In addition, the remarkably low 30-day readmission rate to ADATCs (not shown) has remained fairly unchanged from SFY 2002-03 and SFY 2006-07 (0.3%). **The Division expects to see readmissions to state psychiatric hospitals decrease in coming years as LMEs continue to implement local crisis plans.**

[6] The numbers for SFY 2006-07 are preliminary. They will be final in November 2007 and updated in future reports.





Measure 3.4: Transitions to Community from State Developmental Centers

The Division is committed to increasing opportunities for individuals with developmental disabilities to live in community settings, when appropriate and desired. Moving from a state developmental center to a community setting requires careful planning and monitoring to ensure a safe and successful transition.

For individuals moving from the state's developmental centers to the community, transition planning begins many months prior to discharge. This involves multiple person-centered planning meetings between the individual, their guardian, the treatment team and the community-based provider that has been selected by the individual and their guardian. Service delivery begins immediately upon leaving the developmental center. In SFY 2006-07, a total of 20 individuals were discharged from the general

population of the developmental centers to the community.[7] All twenty individuals went directly from services at the developmental centers to services in the community. Table 3.4 shows the type of community setting to which the individuals moved. Almost half of the consumers moved to an ICF-MR group home during SFY 2006-07.

Table 3.4
Follow-Up Care for DD Consumers Discharged from State Developmental Centers
SFY 2006-07

Time Period	Number of Individuals Moved to Community	Type of Community Setting
July – September 2006	7	3 to ICF-MR group home 3 to supervised living home 1 to alternative family living home
October – December 2006	2	2 to ICF-MR group home
January – March 2007	4	2 to supervised living home 1 to ICF-MR group home 1 to alternative family living home
April – June 2007	7	3 to ICF-MR group home 2 to alternative family living home 1 to supervised living home 1 to natural family

As progress is made on the state's strategic objective to stabilize the provider system, the Division expects to see more people discharged from the state-operated developmental centers to community settings with continuation of the thorough pre-discharge planning and transitional care that is currently provided.

Domain 4: Consumer-Friendly Outcomes

Consumer Outcomes refers to the impact of services on the lives of individuals who receive care. One of the primary goals of system reform is building a recovery/stability-oriented service system. Recovery and stability for a person with disabilities means having independence and control over one's own life, being

[7] This number does not include persons discharged from specialty programs or respite care in the developmental centers.

considered a valuable member of one's community and being able to accomplish personal and social goals.

All people – including those with disabilities – want to be safe, to engage in meaningful daily activities, to enjoy time with supportive friends and family, and to participate positively in the larger community. The SAMHSA National Outcome Measures and the CMS Quality Framework include measures of consumers' perceptions of service outcomes and measures of functioning in a variety of areas, including:

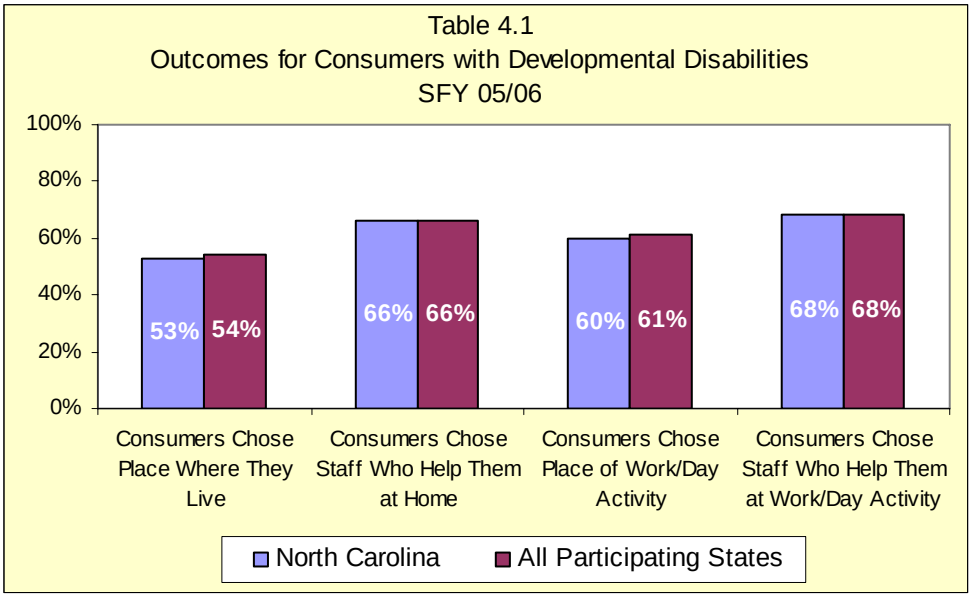
- Symptom reduction, abstinence, and/or behavioral improvements
- Housing stability and independence
- Employment and education
- Social connectedness
- Reduction in criminal involvement

The Division is currently working to ensure that individual progress on these consumer outcomes is addressed as a regular part of developing person-centered plans for every consumer. Based on analysis of current data on consumer outcomes, the Division has adopted improvements in two of these areas – housing and employment / education – as objectives in the *State Strategic Plan 2007-2010* to be addressed over the next three years.

Measure 4.1: Outcomes for Persons with Developmental Disabilities

In annual interviews with DD consumers in 2006, most individuals in North Carolina reported having input into life decisions, such as home and work (Table 4.1). Across all four measures related to housing and employment, North Carolina was approximately the same as the average among all states using the survey. (See Appendix C for details on this survey.) Over half of consumers with developmental disabilities reported choosing where they live and two-thirds reported choosing the staff that help them in their home. In addition, 60% of consumers reported choosing their place of work or day activity, and over two-thirds reported choosing the staff who assist them in their work or day activity.

Table 4.1
Outcomes for Consumers with Developmental Disabilities
SFY 05/06



Recently the Division formed a workgroup tasked to develop outcome measures for consumers with developmental disabilities to be included in the outcomes system currently used with all mental health and substance abuse consumers. This will allow more comprehensive tracking of life outcome changes for the developmental disability population on an ongoing basis and incorporation of that information into the person-centered planning process.

Measure 4.2: Outcomes for Persons with Mental Illness

For persons with mental illness, SAMHSA is focusing National Outcome Measures on reducing symptoms that limit consumers' ability to maintain positive, stable activities and relationships. Successful engagement in services for even three months can improve consumers' lives, as shown in data from consumer interviews below. (See Appendix C for details on the NC-TOPPS system used to collect this data.)

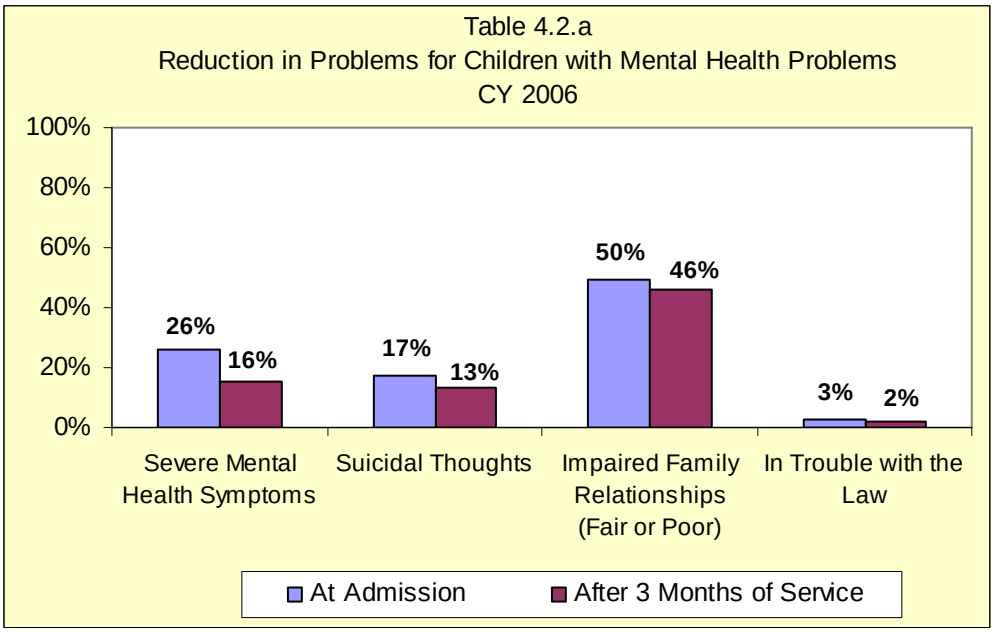


Table 4.2.a shows improvement in the lives of children under age 12 with mental health problems (who received three months of treatment during Calendar Year 2006) in the following four areas: severe mental health symptoms, suicidal thoughts, impaired family relationships, and trouble with the law. All of these areas showed improvements after three months of treatment, the most noticeable being a ten percentage point drop in severe mental health symptoms.

Table 4.2.b, on the next page, shows improvement in the lives of adolescents (ages 12 to 17) with mental health problems (who received three months of treatment during Calendar Year 2006) in the following areas: problems in school, severe mental health symptoms, suicidal thoughts, impaired family relationships, and trouble with the law. Adolescents show improvements in all of these areas after three months of service. The most improvement is seen in a twelve percentage point decrease in adolescents getting in trouble with the law, along with decreases of ten percentage points each in problems with school and in suicidal thoughts.

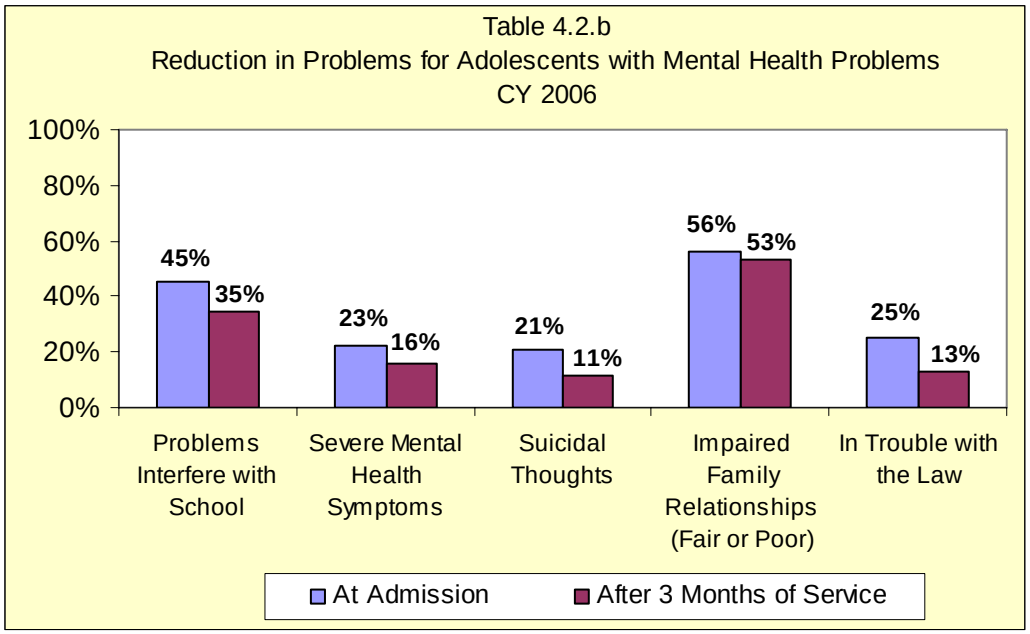


Table 4.2.c shows the progress of adults with mental health problems in reducing their symptoms and the problems associated with those symptoms after only three months of treatment. Similar to children, the greatest gain was in reducing the severity of mental health symptoms (down 15 percentage points). The next greatest improvements were in reduction of problems with work or other activities (down 10 points) and suicidal thoughts (down 9 points).

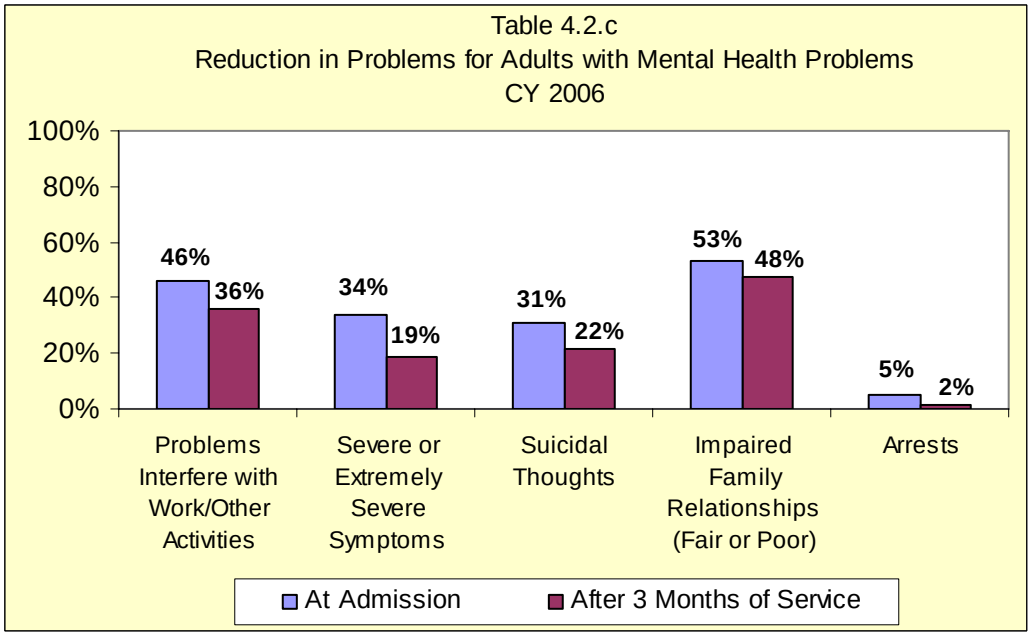
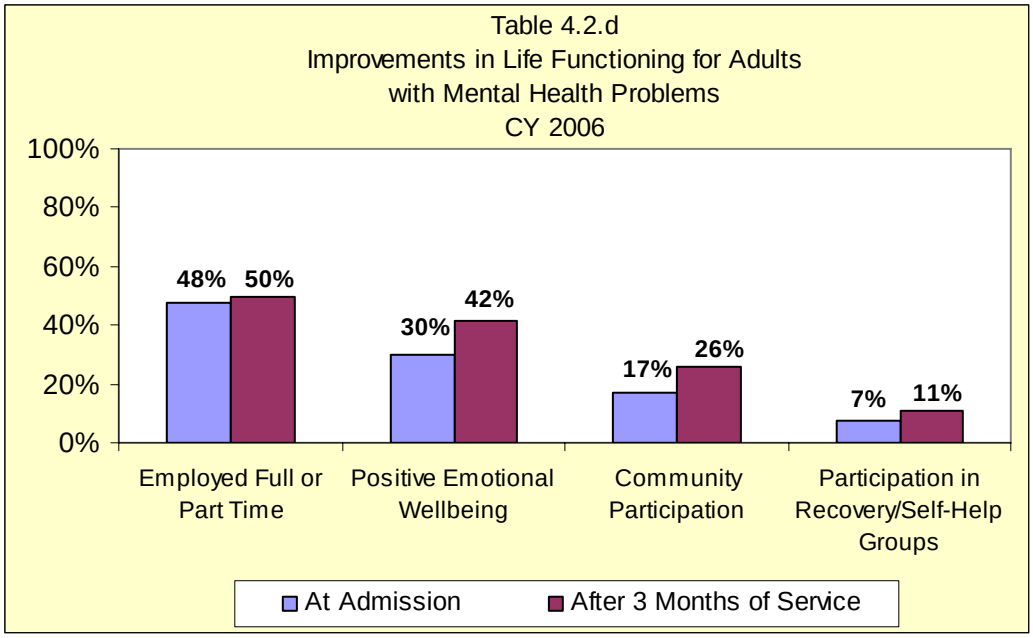


Table 4.2.d shows that three months of service also made a positive difference in the quality of life for adults with mental health problems.

- The percent of adults employed full or part-time increased slightly.
- The percent of adults reporting positive emotional wellbeing was increased by almost half.
- The percent of adults participating in positive community activities increased by over one-third.
- The percent of adults participating in recovery or self-help groups increased by more than half.



While outcomes for adult mental health consumers are all positive, room for improvement remains, especially in the areas of employment and participation in self-help groups and other community activities. Adults, as well as children and adolescents, who remain engaged in services for more than three months can be expected to continue improving in all of the areas shown above. **As the Division and local partners develop and implement strategies to improve education and employment outcomes for consumers over the next three years, the Division expects to see long lasting improvements in these areas.**

Measure 4.3: Outcomes for Persons with Substance Abuse Disorders

SAMHSA National Outcome Measures for persons with substance abuse problems focus on eliminating the use of alcohol and other drugs in order to improve consumers' well-being, social relationships and activities. Successful initiation and engagement in services with this population can have very positive results in a short time, as shown in the data from consumer interviews below. (See Appendix C for details on the NC-TOPPS system used to collect this data.)

Table 4.3.a, on page 26, shows that the lives of adolescents (ages 12 to 17) with substance abuse problems who received three months of treatment during Calendar Year 2006 improved meaningfully in a variety of areas. Most notably, the percent of youth in trouble with the law decreased by over two-thirds and those who used substances dropped by well over half. In addition youth with problems at school were decreased by ten percentage points.

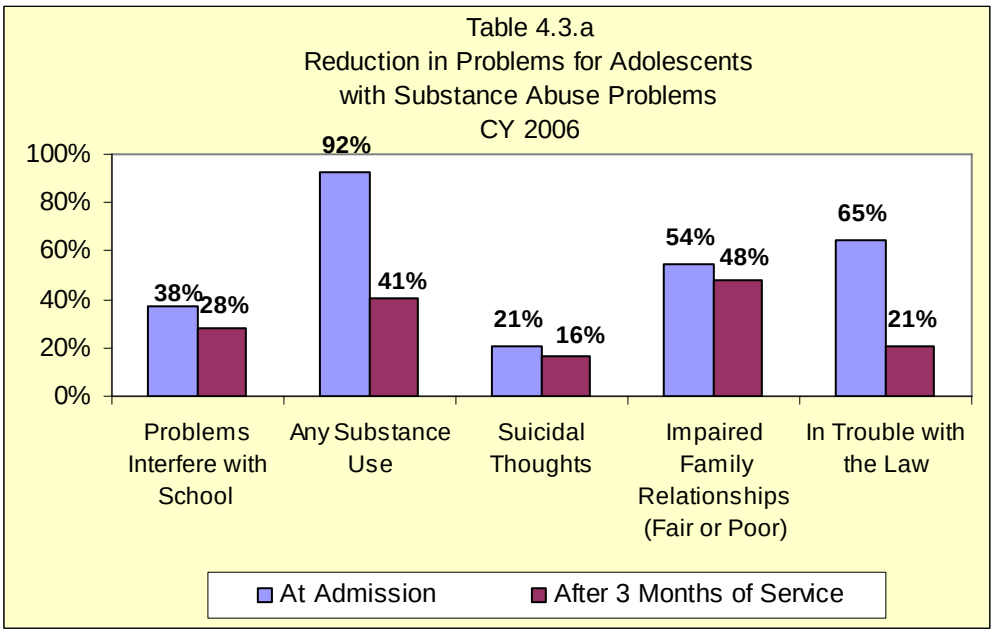


Table 4.3.b shows similar progress among adult substance abuse consumers in reducing substance use and related problems. The percent of adults arrested dropped by over three-fourths and the percents using drugs or alcohol were cut by about two-thirds. In addition, the percent of adults reporting suicidal thoughts was cut almost in half.

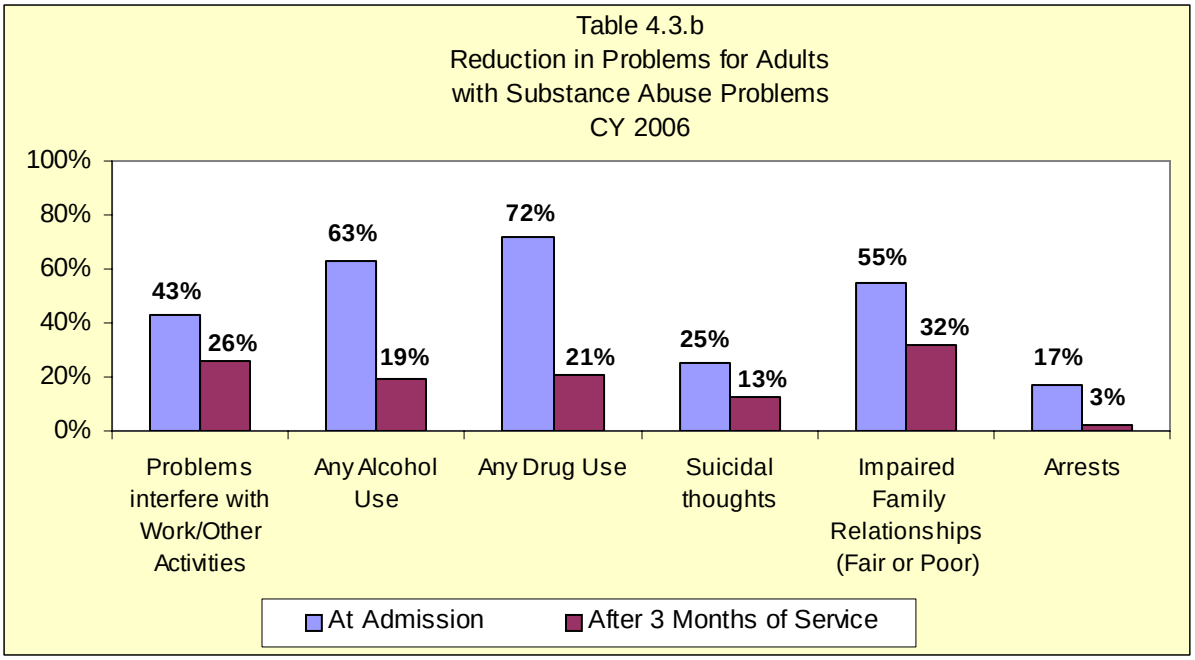
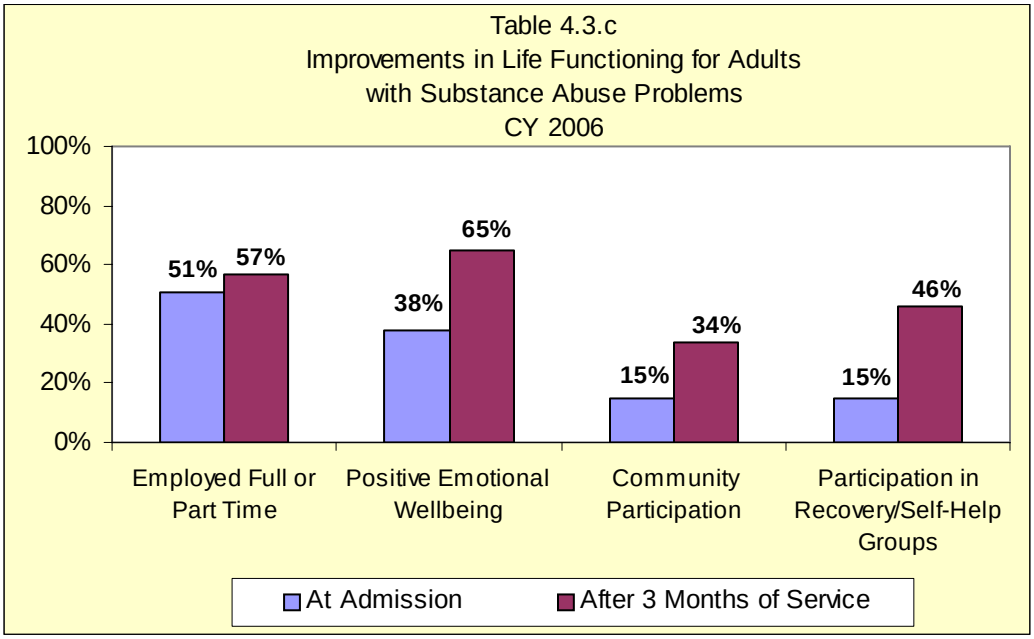


Table 4.3.c, on page 27, shows that services also had a positive impact on the quality of life of adult substance abuse consumers.

- The percent of adults employed full or part-time increased slightly.
- The percent of adults reporting positive emotional wellbeing increased by almost three-fourths.
- The percent of adults participating in positive community activities more than doubled.
- The percent of adults participating in recovery or self-help groups more than tripled.



As seen for adult mental health consumers, helping adult substance abuse consumers maintain and improve their employment situation is an area with room for improvement. The Division expects those who remain engaged in services for more than three months to continue improving in this and other areas of their lives.

The Division expects that the state's focus on education and employment opportunities will sustain and improve outcomes in these areas for adults and adolescents who remain engaged in services for more than the three months reported here.

Domain 5: Quality Management Systems

Quality Management refers to a way of thinking and a system of activities that promote the identification and adoption of effective services and management practices. The Division has embraced the CMS Quality Framework for Home and Community-Based Services, which includes four processes that support development of a high-quality service system:

- **Design**, or building into the system the resources and mechanisms to support quality.
- **Discovery**, or adopting technological and other systems to gather information on system performance and effectiveness.
- **Remediation**, or developing procedures to ensure prompt correction of problems and prevention of their recurrence.

- **Improvement**, or analyzing trends over time and patterns across groups to identify practices that can be changed to become more effective or successful.

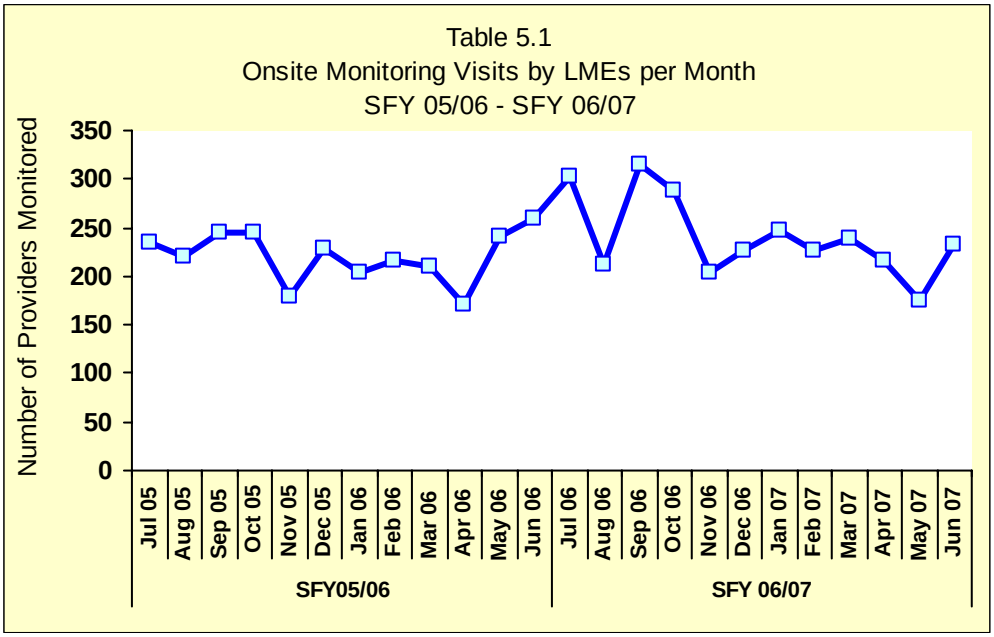
These processes include activities to ensure a foundation of basic quality and to implement ongoing improvements. The first set of activities, often labeled **quality assurance**, focuses on compliance with rules, regulations and performance standards that protect the health, safety and rights of the individuals served by the public mental health, developmental disabilities and substance abuse services system. The second set of activities, labeled **quality improvement**, focuses on analyzing performance information and putting processes in place to make incremental refinements to the system.

Measure 5.1: Assurance of Basic Service Quality

The separation of service delivery from service oversight has been a major goal of system reform. In addition to requirements in the *DHHS-LME Performance Contract* that LMEs monitor the quality of services provided by private agencies, the Division and DMA are working with LMEs to improve and standardize the process for endorsing provider agencies to bill for Medicaid-funded services and the process for conducting post-payment reviews of the services those providers deliver.

As Table 5.1 shows, the number of monitoring visits conducted by the LMEs (including endorsement and post-payment review visits) has fluctuated over the past two state fiscal years. The average number of visits per month rose from 221 in SFY 2005-06 to an average of 240 per month in SFY 2006-07. The peak in monitoring during the summer of 2006 reflects a period of intense LME activity to evaluate providers' eligibility to deliver the newly adopted enhanced services. Likewise, the rise in June 2007 reflects LMEs' intensive review of community support services. **The Division expects a continued increase in monitoring activities through the fall, as LMEs re-evaluate providers' eligibility for full endorsement to deliver the enhanced services.**

Table 5.1
Onsite Monitoring Visits by LMEs per Month
SFY 05/06 - SFY 06/07



In addition to guiding LMEs' scrutiny of provider qualifications to deliver enhanced services, the Division is currently revising the rules and reporting requirements that guide LMEs' oversight of

providers. These changes will standardize local monitoring decisions and improve coordination of monitoring activities among DHHS agencies.

Measure 5.2: Quality Improvement Activities

The *DHHS-LME Performance Contract* also requires LMEs to conduct quality improvement projects. The purpose of this requirement is to ensure that each LME includes an ongoing, systematic quality improvement process as an integral part of its planning and policy-making activities. In SFY 2006-07 LMEs reported an average of five projects each, with a minimum of three and a maximum of eight projects per LME. For each project the LME is expected to report on:

1) the basis for choosing the issues targeted for improvement (e.g. data analyzed),
2) strategies developed to address identified issues,
3) actions taken,
4) an evaluation of results to date, and
5) recommendations for next steps.

Table 5.2 gives a glimpse of the types of issues that LMEs are addressing in their improvement efforts. The Division has strongly encouraged LMEs to use data from the state's standardized incident reporting system to identify problem areas and to track improvements. LMEs have more recently begun using data from the *Community Systems Progress Indicators Report* series to guide improvement activities as well. Both are reflected in the choice of improvement projects shown in Table 5.2.

Table 5.2

Most Frequent Quality Improvement Initiatives

Topic	Number of LMEs
Improving Incident Reporting	14
Improving Continuity of Care	14
Increasing Crisis Services	11
Increasing Use of Evidence-Based Practices	9
Improving Communications with Providers and/or Consumers	8

The Division expects the LMEs' future improvement initiatives to reflect the objectives of their Local Business Plans that were developed to help achieve the statewide objectives of the *State Strategic Plan 2007-2010* and to address areas for local improvement as indicated in the *Community Systems Progress Indicators Reports*.

Domain 6: System Efficiency and Effectiveness

System Efficiency and Effectiveness refers to the capacity of the service system to use limited funds wisely -- to serve the persons most in need in a way that ensures their safety and dignity while helping them to achieve recovery and independence. An effective service system is built on an efficient

management system, key features of which include good planning, sound fiscal management and thorough information management.

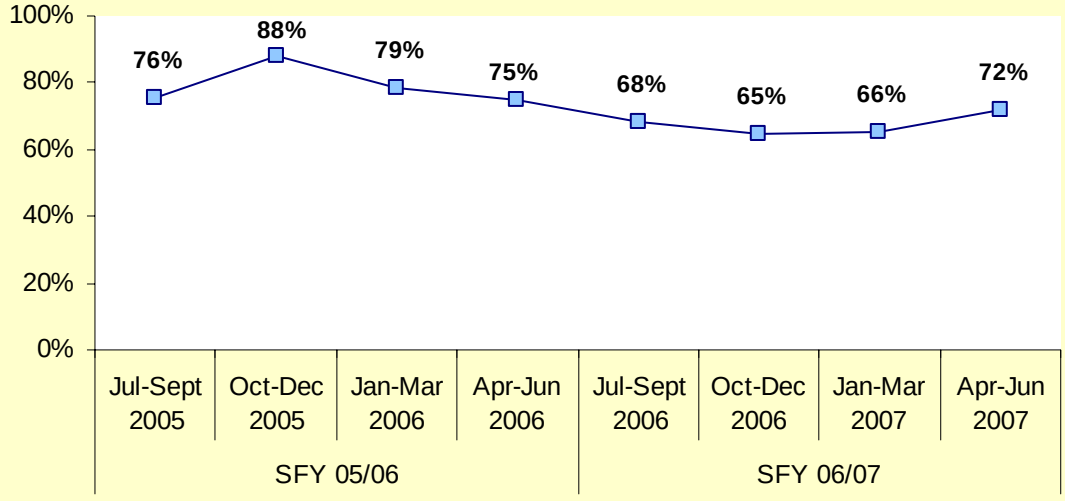
The *DHHS-LME Performance Contract* serves as the Division's vehicle for evaluating LME efficiency and effectiveness. As mentioned earlier, the Division has developed a new annual contract to replace the existing three-year contact. It includes a standardized scope of work detailing the components of each function that the LMEs are expected to perform and critical performance indicators for each function. Several of the performance indicators will coincide with measures reported quarterly in the *Community Systems Progress Indicators Reports* and included in this report.

Measure 6.1: Business and Information Management

Making good decisions requires the ability to get accurate, useful information quickly, easily and regularly. It also requires efficient management of scarce resources. Staff at all levels need to know the status of their programs and resources in time to take advantage of opportunities, avoid potential problems, make needed refinements and plan ahead.

Consumer data, along with service claims data reported through the Integrated Payment and Reimbursement System, the Medicaid claims system, and the Healthcare Enterprise Accounts Receivable Tracking System, also provide the information that the LMEs and the Division use to evaluate local and state system performance and to keep the Legislature informed of system progress through this report.

Table 6.1
Percentage of Data Submission Standards Met for DHHS-LME Performance Contract
SFY 05/06 - SFY 06/07



For these reasons, compliance is critical to LME and Division efforts to manage the service system. The *DHHS-LME Performance Contract* includes requirements for timely and accurate submission of financial and consumer information. Taken together, the LMEs' compliance with reporting requirements provides an indication of the system's capacity for using information to manage the service system efficiently and effectively.

As shown in Table 6.1, local management entities' submission of timely and accurate information to the Division has improved somewhat in the last two quarters of SFY 2006-07, after falling during the

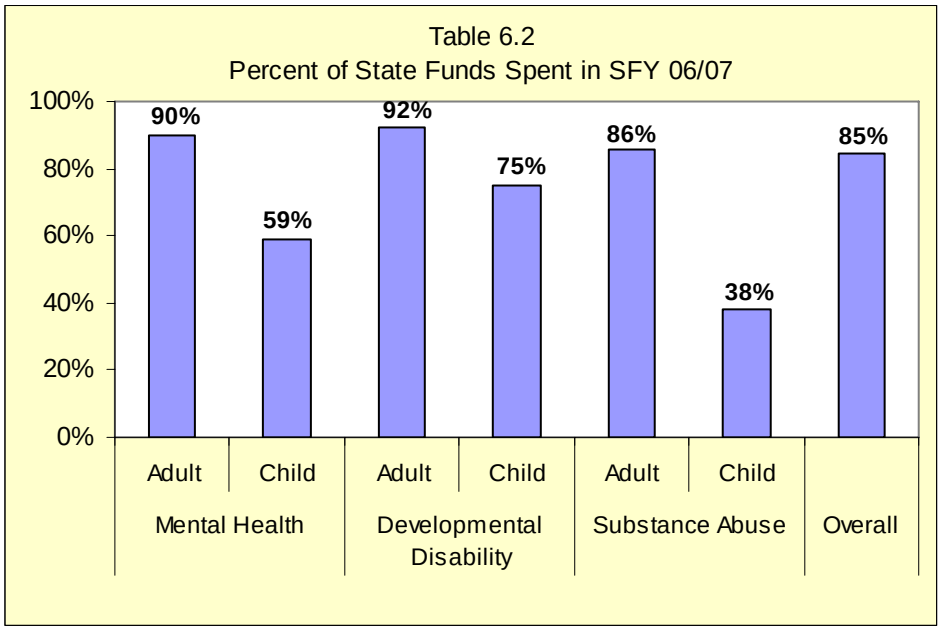
previous four quarters. Much of the drop in the first two quarters of SFY 2006-07 reflects poor performance on the added requirement for submission of NC-TOPPS Update Interviews.

Since much of the LMEs' data on consumers now comes from private providers, additional training and communication between LMEs and providers is necessary to ensure the timely flow of information. The Division provides ongoing monitoring and technical assistance to LMEs to help ensure the timely and accurate flow of information. The LMEs, in turn, use provider compliance with data reporting requirements, as a factor in determining their provider monitoring decisions. **The Division expects compliance to continue increasing as a result of current training and monitoring efforts.**

Measure 6.2: Efficient Management of Service Funds

Providing effective services requires careful management of limited fund allocations over the course of the fiscal year to ensure that funds are continuously available to serve those most in need, without being left unspent at the end of the fiscal year. Overspending of funds early in the year leaves no reserves for those who enter the system or continue to need services later in the year. Underspending of funds means that some who could have been served were not.

Table 6.2 shows the average LME expenditures of state funds during SFY 2006-07 by age-disability group, with an average of 85% spent across all age-disability groups.[8] Of all the disability groups, the expenditures for SA consumers lagged behind the others. In fact, only 38% of the allocations for child SA services were expended in SFY 2006-07. In addition, more funds were spent on adult consumers compared to child consumers (ages 0-17) across all the disability groups.



The lower spending on children's services reflects the greater eligibility of children for Medicaid-funded services, compared to adults. In particular, children in residential services are more likely to receive Medicaid funding. Children receiving family-based services, such as IIH and MST, are less likely to be

[8] Ideally 100% of funds would be spent by the end of the fiscal year.

Medicaid eligible. **As the availability of family-based services increases, the Division expects the expenditure of state dollars for child services to rise.**

The lack of services delivered to SA consumers is due, in part, to a lack of adequate provider capacity, coupled with broad societal stigma against substance abuse and many individuals' reluctance to seek help from the public system. The Division, LMEs and providers must make greater efforts to identify, recruit and engage these consumers. In addition, the state continues to have a great need for additional qualified SA providers. **The Division expects regular tracking and reporting of expenditure disparities among age-disability groups and efforts to recruit and retain additional SA providers to create gradual improvement in this area. Efforts to provide welcoming, accessible, and effective substance abuse services will also be critical for improvements.**

Domain 7: Prevention and Early Intervention

Prevention and Early Intervention refers to activities designed to minimize the occurrence of mental illness, developmental disabilities, and substance abuse whenever possible and to minimize the severity, duration, and negative impact on persons' lives when a disability cannot be prevented. **Prevention** activities include efforts to educate the general public, specific groups known to be at risk, and individuals who are experiencing early signs of an emerging condition. Prevention education focuses on the nature of mh/dd/sa problems and how to prevent, recognize and address them appropriately. **Early intervention** activities are used to halt the progression or significantly reduce the severity and duration of an emerging condition.

Measure 7.1: North Carolina Strategic Prevention Framework State Incentive Grant

In 2005, North Carolina was among the second cohort of states to receive a Strategic Prevention Framework State Incentive Grant (SPF SIG) from the federal Center for Substance Abuse Prevention (CSAP). The SPF SIG is SAMHSA's major demonstration project to train states in the use of their new model for planning and delivering services.

The SPF is a planning model for prevention that is equally relevant for substance abuse, mental health promotion, and other prevention areas. It consists of five basic steps that each incorporate the collection and use of data and require attention to cultural competency and sustainability of efforts. The five steps include:

- Needs Assessment
- Capacity Building
- Strategic Planning
- Implementation of Evidence-Based Programs, Policies, and Practices (EBPPPs)
- Evaluation and Monitoring

All of these steps are part of a circular process. Beginning with the assessment, each state first conducts a statewide needs assessment using indicators of the consumption patterns and community-level consequences of substance use to identify statewide priorities for prevention efforts. Next, states build state and local capacity to address the priorities, develop and implement a strategic plan, and finally evaluate the process and outcomes of the efforts. As with most processes, some of these steps may occur simultaneously. Data are used throughout to drive both the *focus* of prevention efforts and the *types* of prevention efforts. In addition, data are to be used to direct, modify, and assess efforts through out the process.

Through the SPF SIG, North Carolina will receive up to $2.35 million per year for five years, of which 85% will support communities' capacity-building and service-delivery activities and 15% will support administration activities, including the statewide needs assessment, planning, and evaluation activities.

The overarching goals of the SPF-SIG are to:

- Prevent the onset and reduce the progression of substance abuse, including underage drinking,
- Reduce substance-related problems in communities,
- Build prevention capacities and infrastructure at State and community level,

and ultimately to,

- *Implement a process of infusing data across all SPF steps for improved decision-making*

The Division, with the help of partners from a variety of state agencies, universities, and local research firms, has completed the statewide needs assessment and chosen alcohol-related motor vehicle crashes as the highest priority issue that is affecting North Carolina's communities. The *State Epidemiological Profile*, including a description of the process and the data analyzed, and the resulting *SPF SIG Strategic Plan*, are published at http://www.ncspfsig.org/.

Table 7.1 on page 34, shows the eighteen counties and twelve LMEs that were identified during the needs assessment process as most affected by this community problem. These predominantly rural counties will receive funding and technical assistance to conduct local assessments to identify the particular populations and geographic areas most affected by alcohol-related vehicle crashes and to select and implement strategies to reduce this problem in their communities.

Table 7.1

LMEs and Counties Selected for SPF SIG Prevention Initiatives

LMEs	Counties
Albemarle	Dare
CenterPoint	Stokes
Crossroads	Surry
East Carolina Behavioral Health	Gates
Eastpointe	Duplin, Sampson
Five County	Franklin, Vance
Foothills	Alexander, McDowell
Onslow-Carteret	Onslow
Sandhills	Hoke
Southeastern Center	Brunswick
Southeastern Regional	Columbus, Robeson
Smoky Mountain	Cherokee, Jackson, Watauga

The Division expects this prevention initiative to have a positive impact on the capacity of the state to address substance abuse issues. In addition, the Division expects the SPF model to have a spill-over effect that improves assessment and planning efforts in other areas for the LMEs that are involved in this project.

Conclusion

As shown in the measures reported here, the North Carolina system for mental health, developmental disabilities and substance abuse services has made steady progress in many areas, while facing persistent challenges in others. Notable improvements include the continued expansion of a broad new provider system with improved local monitoring of provider quality. Consumer satisfaction and outcomes continue to be strong across all age-disability groups, although education and employment outcomes – two of the Division's strategic objectives for the next three years – still have room for improvement.

The two primary areas of concern continue to be improving services to individuals with substance abuse problems and reducing the use of state psychiatric hospitals for short-term crisis care that could be better delivered in communities.

The Division continues to work with its partners to identify means of addressing the substance abuse issues. The Division's strategic objective on developing a stable, qualified provider community will focus

on filling the gap in qualified substance abuse providers that limits ready initiation of services and engagement of individuals with substance abuse problems. In addition, the SPF SIG project has been designed to build local capacity to prevent substance abuse and its impact on communities.

The Division is concentrating its efforts to minimize the need for short-term hospitalization by ensuring that LMEs implement comprehensive crisis plans and develop stable, high-quality community provider systems. In addition, the Division is working to educate providers on the critical role that clinical home providers play in developing appropriate person-centered plans that address how to minimize crises among high-risk consumers and how to respond to crises quickly and effectively without hospitalization.

Overall, it is clear that system transformation is working, albeit slower than desired, through thoughtful development of a wide array of accessible, evidence-based community services and effective management and oversight of those services.

Appendix A: SAMHSA National Outcome Measures

Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMs)

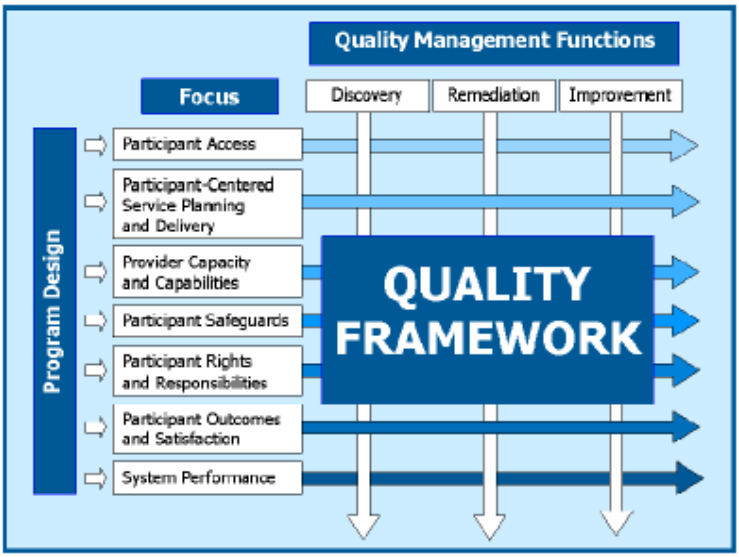
DOMAIN	OUTCOME	MEASURES		
		Mental Health	Substance Abuse	
			Treatment	Prevention
Reduced Morbidity	Abstinence from Drug/Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ▶	30-day substance use (non-use/reduction in use) ▶ Perceived risk/ harm of use ▶ Age of first use ▶ Perception of disapproval/attitude
	Decreased Mental Illness Symptomatology	Under Development	NOT APPLICABLE	NOT APPLICABLE
Employment/ Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ▶	Increase in/no change in number of employed or in school at date of last service compared to first service ▶	Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ▶	Alcohol-related car crashes and injuries; alcohol and drug-related crime
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ▶	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ▶	NOT APPLICABLE
Social Connectedness	Increased Social Supports/Social Connectedness[1]	Under Development	Under Development	Family communication around drug use
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ▶	Unduplicated count of persons served; penetration rate-numbers served compared to those in need ▶	Number of persons served by age, gender, race and ethnicity
Retention	Increased Retention in Treatment - Substance Abuse	NOT APPLICABLE	Length of stay from date of first service to date of last service ▶ Unduplicated count of persons served ▶	Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message
	Reduced Utilization of Psychiatric Inpatient Beds - Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ▶	NOT APPLICABLE	NOT APPLICABLE
Perception of Care	Client Perception of Care[2]	Clients reporting positively about outcomes ▶	Under Development	NOT APPLICABLE
Cost Effectiveness	Cost Effectiveness (Average Cost)[2]	Number of persons receiving evidence-based services/number of evidence-based practices provided by the State	Number of States providing substance abuse treatment services within approved cost per person bands by the type of treatment	Services provided within cost bands
Use of Evidence-Based Practices	Use of Evidence-Based Practices[2]		Under Development	Total number of evidence-based programs and strategies

[1] For ATR, "Social Support of Recovery" is measured by client participation in voluntary recovery or self-help groups, as well as interaction with family and/or friends supportive of recovery.
[2] Required by 2003 OMB PART Review.

Appendix B: CMS Quality Framework

HCBS QUALITY FRAMEWORK

The Home and Community-Based Services (HCBS) Quality Framework provides a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of community services and supports for older persons and individuals with disabilities. The Framework focuses attention on participant-centered **desired outcomes** along seven dimensions.



Program design sets the stage for achieving these desired outcomes. Program design addresses such topics as service standards, provider qualifications, assessment, service planning, monitoring participant health and welfare, and critical safeguards (e.g., incident reporting and management systems).

Quality management encompasses three functions:

- **Discovery:** Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.
- **Remediation:** Taking action to remedy specific problems or concerns that arise.
- **Continuous Improvement:** Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.

Focus	Desired Outcome
Participant Access	*Individuals have access to home and community-based services and supports in their communities.*
Participant-Centered Service Planning and Delivery	*Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community*
Provider Capacity and Capabilities	*There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
Participant Safeguards	*Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
Participant Rights and Responsibilities	*Participants receive support to exercise their rights and in accepting personal responsibilities.*
Participant Outcomes and Satisfaction	*Participants are satisfied with their services and achieve desired outcomes.*
System Performance	*The system supports participants efficiently and effectively and constantly strives to improve quality.*

Quality management gauges the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes.

Program design features and quality management strategies will vary from program to program, depending on the nature of the program's target population, the program's size and the services that it offers, its relationship to other public programs, and additional factors.

The Framework was developed in partnership with the National Associations of State Directors of Developmental Disabilities Services, State Units on Aging, and State Medicaid Directors.

CMS Centers for Medicare & Medicaid Services · NASDDDS National Association of State Directors of Developmental Disabilities Services · NASUA · APHSA American Public Human Services Association

Appendix C: Description of Data Sources

Domain 1: Access to Services

Tables 1.1.a – 1.1.c Persons Served: The Division Client Data Warehouse (CDW) provides data on persons served. This system is the primary repository for data on persons receiving public mental health, developmental disabilities, and substance abuse services. It contains consumer demographic and diagnostic information from extracts of the LMEs' management information systems and DHHS service reimbursement systems. It also contains information on consumers' use of state-operated facilities and consumer outcomes extracted from the HEARTS and NC-TOPPS systems described below.

The number of persons served (unduplicated) is calculated by adding the active caseload at the beginning of the fiscal year (July 1) and all admissions during the fiscal year (July 1 through June 30) and subtracting discharges during the fiscal year. The disability of the consumer is based on the diagnosis reported for the consumer on paid IPRS and/or Medicaid service claims. The consumer's age on June 30 at the end of the fiscal year is used to assign the consumer to the appropriate age group (e.g. children or adults).

Table 1.2 Persons Seen within Seven Days of Request: This measure is calculated by dividing the number of persons requesting routine (non-urgent) care into the number who received a service within the next seven days and multiplying the result by 100. The information comes from data submitted by LMEs and published in the *Quarterly DHHS-LME Performance Contract Reports* for SFY 2006 – SFY 2007. The sources are LME screening, triage, and referral logs and quarterly reports submitted by the LMEs. The data reflect consumers who requested services from an LME. It does not include data on consumers that directly contacted a provider for an appointment. The Division verifies the accuracy of the information through annual on-site sampling of records. More information on the *DHHS-LME Performance Contract*, including the quarterly reports, can be found on the web at: http://www.ncdhhs.gov/mhddsas/performanceagreement/.

Domain 2: Individualized Planning and Supports

Enrolled Qualified Providers: The number of provider agencies enrolled to provide community-based services comes from the Medicaid claims system. As of June 30, 2007, a total of 1,931 community intervention service agencies and 906 providers of Community Alternatives Program for Mental Retardation and Developmental Disabilities (CAP-MR/DD) Waiver services were actively enrolled in the Medicaid claims reimbursement system. An additional 818 child residential facilities in the state are not included.

Tables 2.1.a and 2.2.a Choice among Persons with Developmental Disabilities: The data presented in these tables are from in-person interviews with families of persons with developmental disabilities in the spring of 2006, as part of the National Core Indicators Project (NCIP). This project collects data on the perceptions of individuals with developmental disabilities and their parents and guardians. Approximately 500 in-person interviews with consumers are conducted each year. In addition, over 2,000 mail surveys are sent out each year to parents and guardians of individuals receiving developmental disability services and supports. The interviews and surveys ask questions about service experiences and outcomes of individuals and their families. More information on the NCIP, including reports comparing North Carolina to other participating states on other measures, can be found at: http://www.hsri.org/nci/index.asp?id=reports.

Tables 2.1.b and 2.2.b Choice among Persons with Mental Health and Substance Abuse Disabilities: The SAMHSA-sponsored Mental Health Statistical Improvement Project's Consumer Survey (MHSIP-CS) provides this data. Each LME surveys five percent of its active consumers in the fall of each year. This confidential survey asks questions about the individual's access to services, appropriateness of services, service outcomes, and satisfaction with services. More information on the MHSIP-CS can be found at: http://www.mhsip.org/. Annual reports on North Carolina's survey can be accessed at: http://www.ncdhhs.gov/mhddsas/manuals/.

Domain 3: Promotion of Best Practices

Tables 3.1.a – 3.1.d Providers of Evidence-Based and Best Practices: Information on numbers served in certain services comes from claims data, as reported to Medicaid and the Integrated Payment and Reimbursement System (IPRS).

Tables 3.2.a and 3.2.b Management of State Hospital Usage: The data on state hospital admissions in SFY 2002-03 through SFY 2006-07 comes from the North Carolina Psychiatric Hospital Annual Statistical Report, which is published by the Division and based on data in the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS), the system used to track consumer care in state-operated facilities. This report can be found at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

Table 3.2.c Admissions to ADATC Facilities: The data on admissions to ADATCs in SFY 2002-03 through SFY 2006-07 come from the Division's North Carolina ADATC Annual Statistical Report, which is based on data in HEARTS. This report can be found at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

Tables 3.3.a and 3.3.b State Psychiatric Hospital Readmission: The data on state hospital readmissions (30 days and 180 days after discharge) in SFY 2002-03 through SFY 2006-07 come from the North Carolina Community Mental Health Services Block Grant report, which is based on data from HEARTS.

Table 3.4 Follow-up Care for Consumers Discharged from State Developmental Centers: These data are for SFY 2006-07 and come from reports submitted quarterly by the developmental centers to the Division. The numbers do not include persons discharged from specialty programs (such as programs for persons with both mental retardation and mental illness) or persons who were discharged after receiving respite care only.

Domain 4: Consumer Outcomes

Table 4.1 Outcomes for Persons with Developmental Disabilities: This information comes from NCIP, described in Tables 2.1.a and 2.2.a on the previous page.

Tables 4.2.a - 4.3.c Service Outcomes for Individuals with Mental Health and Substance Abuse Disabilities: This information comes from the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS). This web-based system collects information on a regular schedule through clinician-to-consumer interviews for all persons ages 6 and over who receive mental health and substance abuse services. More information on NC-TOPPS, including annual reports on each age-disability group, can be found at http://nctopps.ncdmh.net/.

Domain 5: Quality Management

Table 5.1 Assurance of Basic Service Quality: The information comes from data submitted by LMEs and published in the *Quarterly DHHS-LME Performance Contract Reports* for SFY 2005-06 through

SFY 2006-07 by the Division. The Division verifies the accuracy of the information through annual on-site sampling of records.

Table 5.2 Quality Improvement Activities: The information on LMEs' quality improvement activities comes from annual Quality Improvement reports that the LMEs submitted to the Division in July 2007 as part of their *DHHS-LME Performance Contract* requirements.

Domain 6: Efficiency and Effectiveness

Table 6.1 Business And Information Management: Table 6.1 includes timely, complete and accurate submission of information required in the *DHHS-LME Performance Contract* over the last two years. The Contract includes measures on LME submission of consumer data to the CDW, NC-TOPPS, the Developmental Disabilities-Consumer Outcomes Inventory (DD-COI), and NC Service Needs Assessment Profile (NC SNAP). It also includes timely submission of reports detailing progress on the LMEs' Local Business Plans and use of federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds. Data submission requirements have changed during the past two years, due to the discontinuation of some elements (e.g. DD-COI) and the addition of new elements (e.g. CDW screening data). In addition, the reporting frequency for SAPTBTG reports varies from quarterly to annually. For these reasons, the number of requirements included in the denominators for Table 6.1 fluctuates between 7 and 11 over the eight fiscal quarters represented. More information on the *DHHS-LME Performance Contract*, including the quarterly reports, can be found at: http://www.ncdhhs.gov/mhddsas/performanceagreement/.

Table 6.2 Percent of Funds Spent: These data are calculated by dividing the total annual allocations for State and non-Medicaid Federal Funds as of June 30, 2007 into the total expenditures reported in IPRS for the time period July 1, 2006 – June 30, 2007. Expenditures of the Piedmont and Smoky Mountain LMEs are not included.

Domain 7: Prevention and Early Intervention

Measure 7.1 North Carolina Strategic Prevention Framework State Incentive Grant: Information on the North Carolina Strategic Prevention Framework State Incentive Grant, including the *State Epidemiological Profile* and the *North Carolina SPF SIG Strategic Plan* can be found at: www.ncspfsig.org.